This is a digital copy of a book that was preserved for generations on library shelves before it was carefully scanned by Google as part of a project to make the world's books discoverable online.

It has survived long enough for the copyright to expire and the book to enter the public domain. A public domain book is one that was never subject to copyright or whose legal copyright term has expired. Whether a book is in the public domain may vary country to country. Public domain books are our gateways to the past, representing a wealth of history, culture and knowledge that's often difficult to discover.

Marks, notations and other marginalia present in the original volume will appear in this file - a reminder of this book's long journey from the publisher to a library and finally to you.

Usage guidelines

Google is proud to partner with libraries to digitize public domain materials and make them widely accessible. Public domain books belong to the public and we are merely their custodians. Nevertheless, this work is expensive, so in order to keep providing this resource, we have taken steps to prevent abuse by commercial parties, including placing technical restrictions on automated querying.

We also ask that you:

+ *Make non-commercial use of the files* We designed Google Book Search for use by individuals, and we request that you use these files for personal, non-commercial purposes.

+ *Refrain from automated querying* Do not send automated queries of any sort to Google's system: If you are conducting research on machine translation, optical character recognition or other areas where access to a large amount of text is helpful, please contact us. We encourage the use of public domain materials for these purposes and may be able to help.

+ *Maintain attribution* The Google "watermark" you see on each file is essential for informing people about this project and helping them find additional materials through Google Book Search. Please do not remove it.

+ *Keep it legal* Whatever your use, remember that you are responsible for ensuring that what you are doing is legal. Do not assume that just because we believe a book is in the public domain for users in the United States, that the work is also in the public domain for users in other countries. Whether a book is still in copyright varies from country to country, and we can't offer guidance on whether any specific use of any specific book is allowed. Please do not assume that a book's appearance in Google Book Search means it can be used in any manner anywhere in the world. Copyright infringement liability can be quite severe.

About Google Book Search

Google's mission is to organize the world's information and to make it universally accessible and useful. Google Book Search helps readers discover the world's books while helping authors and publishers reach new audiences. You can search through the full text of this book on the web at `http://books.google.com/`

No.

BOSTON
MEDICAL LIBRARY
ASSOCIATION,
19 BOYLSTON PLACE.

THE CINCINNATI

MEDICAL AND DENTAL

JOURNAL.

BOSTON MEDICAL
JUN 20 1888
LIBRARY ASS'N.

MEDICAL DEPARTMENT:

EDITED BY

A. B. THRASHER, A. M., M. D.

DENTAL DEPARTMENT:

EDITED BY

FRANK W. SAGE, D. D. S.

October, 1886. -:- VOLUME II. -:- October, 1887.

CINCINNATI:
Published Monthly by M. A. SPENCER & CO., Surgical & Dental Depot,
195 & 197 West Seventh Street.

CATALOGUED,
R. F. D.
6/20/'88

CONTRIBUTORS.

MEDICAL DEPARTMENT.

Robt. Bartholow, M.D., Philadelphia.
Julia W. Carpenter, M.D., Cincinnati.
J. B. Carpenter, M.D., Stanford, Ky.
John L. Davis, M.D., Los Angelos, Cal.
Francis Dowling, M.D., Cincinnati.
Thos. R. Frazer, M.D., Cincinnati.
Prof. F. W. Langdon, Cincinnati.
Wm. R. Leonard, M.D., New York.
J. C. McMeechan, M.D., Wilmington, O.
E. S. McKee, M.D., Cincinnati,
Wm. A. Pease, M.D., Dayton, O.
A. Ravogli, M.D., Cincinnati.
Konn B. Sayres, M.D., Cincinnati.
Prof. W. W. Seely, Cincinnati.
A. J. Stucky, M.D., Lexington, Ky.
C. W. Tangemann, M.D., Cincinnati.
J. A. Thompson, M.D., Cincinnati.
A. B. Thrasher, A.M., M.D., Cincinnati.
J. P. Turney, M.D., Cincinnati.
W. H. Wenning, M.D., Cincinnati.
Prof. Jas. T. Whittaker, Cincinnati.
Philip Zenner, M.D., Cincinnati.

DENTAL DEPARTMENT.

C. M. Wright, M.D., Cincinnati.
W. W. Wallace, M.D.

INDEX.

MEDICAL DEPARTMENT.

ANAL speculum, a new, 44.
Asthma, 97.
Annual report of the Universal Medical Sciences, 140.
Antipyrine in headaches, 138.
Apoplexy, 161.
A dinner in Central Asia, 177.
Anatomical demonstrations, concerning, 199.
Aphonia from subglottic growth, 200.
Analine oil in phthisis, 233.
Alcohol, some of the therapeutic uses of, 241.
Antipyrine, the uses of for febrile conditions during dentition, 241.
Accouchment during hypnotic sleep, 227.
Aspiration of the urinary bladder, 304.
Abuses of milk diet in therapeutics, 330.
Acromegally, 339.
Antipyretic drugs, effects of on the liver and kidneys, 364.

BARTHOLOW, Robt., M.D.
The Abuse of Milk Diet in Therapeutics, 330.
Boston medical ethics, 12.
Books and pamphlets, 308, 286, 276, 208, 115, 83, 48.
Belladonna in sterility of females, 75.
Belladonna in the treatment of rhus poisoning, 145.
Bergeon treatment of phthisis, 272.
Boracic acid as a milk preservative, 365.

CARPENTER, J. B., M.D., Stanford, Ky.
Carpenter's Snare, 166.
CARPENTER, Dr. Julia W., Cincinnati.
The Career of Women Physicians, 225.
Cincinnati College of Physicians and Surgeons, 14.
Clergyman's sore throat, 15.
Chlorodyne habit, 20.
Condiments for the sick, 52.
"Cuticura," composition of, 51.
Corneal diseases, the management of, 129.
Congenital cyanosis. Death. Post mortem, 134.
Carpenter's snare, 166.
Chorea, school-made, 169.
Compensation of expert witnesses, 172.
Cincinnati Hospital and the medical colleges, 201.
Cincinnati Morgue, the, 202.
Career of women physicians, 225.
Chronic cystitis, 228.
Canal of Petit, existence questioned, 244.
Colorado, the climate of, 275.
Cremation in Cincinnati, 306.
Cocaine in whooping cough, 335.
Chronic cystitis, 337.
Castration of criminals, 368.

DAVIS, Dr. John L.
A Case of Strychnine Poisoning, 65.

DOWLING, Francis, M.D.
Inflammation of the External Ear-Tube, 69.
Darby contempt case, the, 113, 235.
Disinfectants, 115.
Drink for diabetics, 115.
Disinfectants defined, 131.
Diet in diabetes, 148.
Dietary in catarrh of the stomach, the. 175.
Diet for obesity, 200.
Dysphagia of laryngeal phthisis, 203.
Dakota doctor, a, 308.
Dyspnœa, 321.
Diphtheria, 367.

ELECTROLYSIS in stricture of the urethra, 49.
Ear, inflammation of the external tube, 69.
Ear, chronic suppuration of middle, 72.
Explosive mixtures. 104.
Electrolytic destruction of hairs, 144.
Early menstruation and the menopause, 367.

FRAZER, Thos. R., M.D.
Dyspnœa, 321.
Fish as an invalid diet, 20.
Flat chests vs. education, 171.
Fractures of the femur, their treatment and results by a new appliance, 265.

GONORRHŒA from rectal coition, 19.
Gastralgia, treatment of, 359.
Gonorrhœa, treatment of by injections of bicarbonate of sodium, 366.

HYGIENE, report on, 105.
Hygiene of the skin, 176.
Hospital staff, the new, 234.

IRITIS, a very peculiar case of, 10.
Ichthyol and resorcin in treatment of skin diseases, 33.
Instruments, care of, 82,
Intra-pulmonary injections, 114.
Intestinal giddiness, 148.
Infectious diseases, notification of, 165.
Ingenious method of extracting a cockle bur from the larynx, 180.
Ichthyol, 203.
Impurities of ice, 234.
International Medical Congress, the, 307.
Influence of tea, coffee, and cocoa on digestion, 336.

JEFFERSON Medical College, 77.

KNEE-JERK, will the, divide typhoid fever from meningitis, 273.

LANGDON, Prof. F. W.
Report on Hygiene, 105.
LEONARD, Wm. R.. M.D.
A New Anal Speculum, 44.
Latin and Greek for medical students, 147.
Labor among the natives of New Guinea, 178.
Lupus, treatment of, by injections of corrosive sublimate, 340.
Lymphodermia perniciosa, a new skin disease, 367.

McMEECHAN, Dr. Jas. T.
Should Landlords be Compelled to keep their Houses in Good Sanitary Condition, 110.
McKEE, E. S., M.D.
Ætiology of Pruritus Prudendi, 9.
Congenital Cyanosis. Death. Post mortem, 134,
Foreign correspondence, 268, 353.
Miami Medical College, 14.
Medical Department of the Cincinnati University, 15.
Miami Medical College, changes in, 47.
Membraneous croup and diphtheria, 50.
Matriculants in German medical colleges, 77.
Mortality, male and female, in the United States, 115.
Magnetism of the blood, experimental studies on, 167.
Medical Laws, 170.

Maternal impressions on the fœtus in utero, 177.
Medical profession, the, 193.
Multiple epithelium of the gum, a case of, 197.
Minnesota medical law, 202.
Medical practitioners and dentists, 271,
Myxo sarcoma, 301,
Mammary abscess, 338.
Morphine injections, dangers of in strangulated hernia, 368.

NASAL and pharyngo-nasal catarrh, treatment of, 1.
Nursing of children by their mothers, 80.
Nocturnal cough of children, 179.
Neurasthenia, 239.
Nervousness in women, 302.

OVARIOTOMY, a new danger in, 20.
  rapid, 75.
Orchitis, treatment of, 44.
Official insolence rebuked, 46.
Oxygen, the therapeutic value of, 204.

PEASE, Wm. A., M.D., Dayton, O.
  Syphilis as it Affects Dentistry, 289.
Proper gratuity, a, 11.
Pruritus pudendi, ætiology of, 9.
Prescribing druggists and dispensing physicians, 45.
Physical culture for women, 76.
Phthisis, diet in, 71.
  contagion of, 79.
Parasitic skin diseases, a new principle in the treatment of, 80.
Physician's office cabinet, a new, 136.
  vacation, the, 307.
  charges, 357.
Proprietary quacks, 143.
Prolonged lactation on the ovaries, effects of, 147.
Pregnancy complicated with ovarian tumors; tapping, delivery, and subsequent removal of cysts, 243.
Placenta prævia, the treatment of, 299.
Public health, 357.

QUININE as an aphrodisiac, 84.
Quackery, 76.

RAVOGLI, A., M.D.
  Experimental Studies on the Magnetism of the Blood, 167.
  Ichthyol and Resorcin in the Treatment of Skin Diseases, 33.
Responsibility of Druggists, 11.
Requirments of graduation at Berlin, 16.
Rhinological Association, the American, 13, 335.
Reunion of severed fingers, 82.
Rare diseases, 76.
Relation of the diseased nasal mucous membrane to asthma, 233.
Rheumatic cerebro-spinal inflammation.
Removal of small calculi from the bladder in male children, a new process for, 243.
Resorcin in acuminated warts, 366.

SAYRES, Konn B., M.D.
  Concerning Anatomical Demonstrations, 199.
  Chronic Cystitis, 228.
SEELY, PROF. W. W.
  The Management of Corneal Diseases, 129.
STUCKY, A. J., M.D., Lexington, Ky.
  The Treatment of Nasal and Naso-pharyngeal Catarrh, 1.
Stricture of Rectum. 11.
Sciatica treated by galvanism, 18.
Scarlatinal nephritis, 51.
Sleep, position in, 51.
Surgeon-General U. S. A., 78.
Strychnine poisoning, a case of, 65.
Sanitary matters, 81.
Should landlords be compelled to keep their houses in good sanitary condition? 110.
Syphilis from vaccination, 114.
  as it affects dentistry, 289.
Syphilitic disease of the nose, a case of, 132.
Senator Logan, what "killed," 139.
Spiritual doctor, a, 142:
Southwestern Medical Gazette, the, 142.

Starchy foods for infants, 305.
Substitute for a double catheter, 332,
Sunstroke, 333.

TANGEMAN, C. W., M.D.
  A Very Peculiar Case of Iritis, 10.
  Chronic Suppuration of the Middle Ear, 72.
  Transplantation of Living Tissue, 257.
THOMPSON, J. A., M.D.
  A Case of Syphilitic Disease of the Nose, 132.
  A Case of Multiple Epithelium of the Gum, 197.
TURNEY, J. P., M.D.
  Fractures of the Femur, their Treatment and Result, by a New Appliance, 265.
Tracheotomy, long retention of canula after, 8.
Therapeutic action of chloride of sodium, 19.
Tobacco, effects of, 146.
Transplantation of living tissue, 257.
Toxic effects of lead, 329.
Theism, the new nervous disease, 336.
Tea poisoning in the course of syphilis, 458.

URINE, retention of, 267,

VESICAL calculus, large, 52.
Vocalists' soup, 133.

WENNING, W. H., M.D.
  A New Physician's Office Cabinet, 136.
WHITTAKER, PROF. JAS. T.
  Asthma, 97.
  The Medical Profession, 193.
Writer's cramp, 115.
Women's Medical College, 170.
Wonderful homeopathic cases, 307.

ZENNER, Philip, A.M., M.D.,
  Apoplexy, 161.

INDEX.

DENTAL DEPARTMENT.

MISCELLANY.

Dentistry in the year 2186, 21.
Erratum, 27.
Making retaining points, 23.
A new anæsthetic, 28.
Laboratory hints, 28.
Inhaler for ether, 29.
How to bur a cavity, 30.
Improvement in microscope, 31.
Much or little water in vulcanizing, 32.
Repairing soft teeth for filling, 32.
Alveolar abscess, 32.
Dr. Herbst's obtundent. Opinions thereon, 53.
Old and new remedies, 56.
If not, what then? 60.
A startling surgical operation, 63.
To obtain adhesion for artificial plates, 63.
The platina surrounded clasp, 64.
Pearline for removing stains, 64.
Teeth with exposed pulps, 85.
Implantation of teeth, 87.
Isinglass for matrices, 93.
Old saws that ought to be filed, 94.
Dr. McKellop's opinion of wedging, 94.
A specimen of French dentistry, 95.
The amalgam war, 95.
The role of dentition in infantile pathology, 117.
A simple amalgam carrier, 118.
Criticism of the Herbst method, 119.
The little pulp's triumph, 124.
Is this sound doctrine? 126.
Herbst method with gold and amalgam combined, 126.
Engine motor, 128.
Of value to operators, 128.
New use for alloyed foils, 128.
Play on words, 128.
Scrap, 128.
Clamps and ligatures, 149.
Gold and tin as a filling, 150.
Aseptol, 153.
Toxic effects of corrosive sublimate used as an antiseptic, 153.
Effects of mental overwork on the teeth, 154.
Metallic enamel sections, 181.
Impressions, 183.
Treatment of pulpless teeth, 184.
Cause of dark joints, 185.
Absorbent cotton not always best, 191.
Reflex pain, 191.
Rotation as a condensing force, 209.
Swiss jeweler's broach, No. 10, 221.
Hyponaphthol and the potassio-mercuric iodide, 222.
Eugenol, 223.
Injustice to our neighbors, 223.
Various notes, 224.
Irregularities of teeth, 245.
New remedies, 248.
An excellent obtundent, 250.
Dr. Merriam's use of gutta-percha for difficult cavities, 256.
Herbst method vs. the American system of filling teeth with gold, 277.
Crown and bridge work and conservative dentistry, 281.

On regulating teeth, 309.
Immediate root filling, 319.
Torsion of teeth, 320.
Pickle for gold work, 320.
Painless devitalization of pulps, 342.
Dr. Herbst's pin clamps, 343.
To remove rust stains from nickel-plated ware, 343.
Medical cases in court, 344.
Resolution of recognition.—American Medical Association, 343.
Ninth International Medical Congress, 346.
Nerve-paste, improved, 346.
Dr. Wm. Taft's appointment, 346.
An objection to plastic fillings, 352.
Operative dentistry, 373.
Melting point of gold, 376.
Disk cutter, 376.
Solid grinding surfaces for bridge or crown work, 377.
Bridge work, 377.
Observations on artificial crowns, 377.
Pure mercury, 378.

EDITORIAL.

Shall professional men advertise? 24.
The principles involved in the Herbst method of filling teeth, 90.
Secondary dentine under cupped pulps, 127.
Incidents of office practice, 155,
Dr. Harlan on clamps, 157.
The dental review, 159.
A question of responsibility, 187.
The requisite to success in practice, 190.
How shall it be decided? 191.
Convention notes, 218.
Use your magnifier, 247.
Conservatism vs. radicalism, 255.
International Medical Congress, 255.
Miscellany, 284, 287, 288.
The abuse of dental charity, 347.
Are there too many dentists? 350.
Our immense country, 352.
The unrecorded utterances of the lobbies, 369.
What is the best crown, 371.
Constituents of dental cements, 372.
Farewell announcement, 372.

CONTRIBUTIONS.

E. S. CASPER, Texas.

Use of Napkins in Examinations, 29.
Tit for Tat, 190.
New Treatise on Teeth Without Plates, 217.
A Cool Wave Coming; 341.

SOCIETY REPORTS.

Ohio State Dental Society meeting, 27.
Mississippi Valley Dental Association, 158.
Cincinnati Odontological Society, 159.
New York Odontological Society, 186.
Officers Mississippi Valley Association for 1887, 219.
Ohio Dental College commencement and banquet, 220.
Illinois State Society, 121.
New York Odontological Society, 251.
Kentucky Dental Society, 256.
American Dental Association, 318.

BIBLIOGRAPHY.

Review of American system of dentistry, 31, 192.
Index to periodical literature of dental science and art, 31.
A practical treatise on mechanical dentistry, 64.
Discontinued, 160.
Tomes' system dental surgery, 288.

OBITUARY.

Dr. E. Osmond, 96.
Dr. J. P. Ullery, 96.

1114

THE
CINCINNATI
Medical and Dental
JOURNAL

Vol. II. Cincinnati, October, 1886. No. 1.

BOSTON MEDICAL
JOURNAL
JUN 20 1888
LIBRARY ASS'N

MEDICAL DEPARTMENT.

REPORT ON RHINOLOGY:*

The Treatment of Nasal and Pharyngo-Nasal Catarrh.

By ADDISON J. STUCKY, M. D., Lexington, Ky.
Surgeon to St. Joseph's Hospital, Member Kentucky State Medical Society,
Vice President American Rhinological Society.

Until a very few years ago, diseases of the naso-pharyngeal cavities were so little thought of, that they were scarcely noticed by any of the authors of our best text-books. But now the literature on the subject is voluminous; and it seems that the idea is just beginning to dawn upon the minds of the profession that disease of these cavities is the most prolific cause of trouble in the tympanic, pharyngeal and laryngeal cavities, the lachrymal duct and canal, and the conjunctiva. Facial neuralgia, occipital and frontal ache, and impairment of the function of the digestive apparatus and nervous system are also frequently due to it—I might enumerate many symptoms, reflex in their nature, due to the same cause, but think I have mentioned enough to at least awaken some interest in this subject.

I was glad that this Society decided at its last meeting to place rhinology on an equal footing with laryngology, otology and ophthalmology, and it is with no little degree of embarassment that I present this, the first report on the subject. It is not my intention to weary you with a history of rhinology, nor to give a detailed report of its progress during the year that is past. The medical journals all over the land have had so much to say on the subject, that, to do this would be consuming too much valuable time. Taking for granted that most of you, at least, have familiarized yourselves with this, I propose briefly to consider:

---

*Read before Kentucky State Medical Society, at Winchester, June, 1886.

(1) The best method of treating disease of the nasal and pharyngo-nasal cavities.

(2) To mention those remedial agents that have given me best results in the treatment of several different forms of this disease.

At the last meeting of the American Laryngological Association, Dr. J. Solis Cohen says: "The two great principles in the treatment of naso-pharyngeal catarrh were, first, to keep the parts clean, so as to let them have a chance to get well of themselves; and second, to take care of the patient's general health." He depreciates the free (and frequently indiscriminate) use of the knife, drill and cautery, and says: "I have relieved, in many instances permanently, by mild measures, cases in all respects equally severe with those so often treated by ruder methods." This has been my experience, and it is the mild, *non-irritating* treatment that I advocate.

To Dr. Cohen's first maxim, "Keep the parts clean," I would add *protected* and *lubricated;* if this is done, and the patient's general health cared for, the *majority* of cases of chronic nasal catarrh will get well. The impairment of the general health (consequent lowering of the vital forces and involvement of the vaso-motor system) in a large number of cases of this disease, is not, in my opinion, the cause of the disease, but vice versa. But it is more to the local treatment than the constitutional that I desire to call your attention.

In cleansing or medicating the nasal cavities, the method and remedies should be non-irritating, reaching every portion of the diseased surface.

"A method that requires the irritation of the healthy parts to free the diseased surface must do injury to the healthy surface, and the injury thus done to the one is much greater than the benefit done to the other, for the healthy membrane will take on inflammation much faster than the diseased portion will resume its normal condition."

The questions that then present themselves are:

(1) What is the non-irritating remedy?

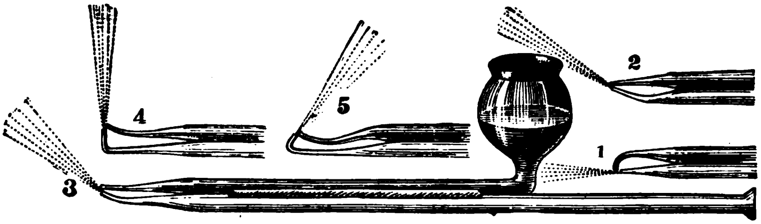
(2) How is it to be used?

To the first I answer, vaseline, in the form of a spray, as applied by Rumbold's method. This remedy is well known to every practitioner, hence needs no description or eulogy. That it is non-irritating, soothing and protecting to an inflamed and diseased surface, I venture to say, none will deny. In my opinion it is the *sine qua non* in diseases of the superior respiratory tract. Used in the manner that I shall presently describe, it fulfills, in a great majority of cases, the indications pointed out by the eminent laryngologist and author referred to, in that it can be made to "thoroughly cleanse the parts," and *lubricate* and *protect* them. I am aware that many eminent in the profession contend that vaseline is not absorbable. I believe that it is; but this cannot be determined by its use in the pharyngo-nasal cavities, but when used on the general surface, as in scarlet fever, or in the external auditory meatus, we know from experience that it is absorbed. If it is not absorbed it would act wholly by its physical properties, but its effects in curing are too great and marked to result from a physical cause alone. That it possesses medicinal properties in no small degree I am well satisfied. These properties I believe to be antiseptic. It acts also as a physical agent by coating the membrane, thus preventing the absorption of moisture and gases, and the contact of dust and other irritants.

Having obtained a non-irritating remedy, we must use a non-irritating method of applying it to the diseased part. In June, 1866, Dr. F. M. Rumbold designed and used a set of instruments —spray producers—which fulfilled in every respect the last indication. The instruments are made so as to spray the entire pharyngo-nasal and laryngo-tracheal space, and "as the diseased surface is not touched by the instrument, but only impinged upon by the air and liquid, and the remedy used is non-irritating, it follows that it is operated upon in the mildest manner possible. These instruments combine with efficacious cleansing and medicating, a thoroughness and mildness that is unequalled by any other method" (Rumbold).

To accomplish these results, the instrument must be made to throw a stream (spray) that is required to make an application to each portion of the diseased surface. To accomplish this, I have found that three spray producers are enough to meet these indications.

Figs. 1 and 2 illustrate the instruments and method of applying the spray.



Spray Producers for making Local Applications to the Nasal and Pharyngo-Nasal Cavities, the Fauces and the Tonsils.

No. 1 treats the tonsils and the fauces; No. 2 the anterior nares; No. 3 the posterior wall of the pharyngo-nasal cavity; No. 4 its superior surface, and by slight rotation its lateral walls, and No. 5 throws the spray into the posterior nasal openings (RUMBOLD).

FIG. I.

(1) One that throws a horizontal stream, for treating the pharynx, tonsils and anterior nares.

(2) One that throws a stream vertically, for treating the superior portion and arched boundary of the pharyngo-nasal cavity, or vault of the pharynx.

(3) One that throws a stream upwards and directly forwards, at an angle of forty-five degrees, treating the posterior nares, edges and sides of the turbinated processes, and septum nasi.

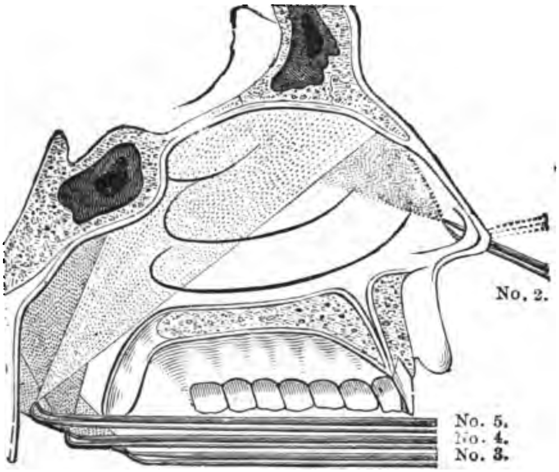


FIG. 2.

I know of no method equal to this; and I have given the post-nasal syringe, douche, powders and swab an impartial trial, and conclude that, this is the only method by which we can thoroughly, mildly and effectually treat these tissues.

In cases of simple chronic catarrh (rhinitis), where the secretions are not very abundant or tenacious, I find that thoroughly spraying the pharyngo-nasal cavity, posterior and anterior nares with warm vaseline, is usually sufficient to bring about a cure in two or three weeks. Compressed air, ten to fifteen pounds to the square inch, is used to produce the spray. This is usually sufficient to thoroughly cleanse and remove the unnatural secretion; and by *lubricating* and *protecting* the parts, nature is given an opportunity to effect the cure. If the case is one of long standing and the muco-purulent secretion is very tenacious and difficult to remove, on account of the membrane being very much swollen, I use the following solution with good results:

℞. Sodium chlor. . . .
Acid boric, āā . . . gr. v.
Sol. cocaine mur., 1 per cent., ℥ i. M.

This is warmed and sprayed into the anterior and posterior nares, and dissolves the tenacious secretion and causes "a contraction of the succulent tissues" so that the patient is able to thoroughly cleanse the nose by blowing it. After this cleansing is accomplished, applications, by means of the spray producer, of warm vaseline with small amount of pinus canadensis or glycerole of tannin completes the treatment. This should be done once daily for a week, then every other day for ten days, then once or twice a week until the cure is completed. Care should be exercised in using the astringent. If the application causes pain, lessen the quantity or discontinue it, and use plain vaseline until the excessive irritability is overcome.

HYPERTROPHIC CATARRH (Rhinitis),

The sequel of chronic catarrh, is by far the most annoying variety of nasal catarrh. It is this that gives rise to a greater number of reflex symptoms and sequelæ, some of which are frontal and occipital ache, facial neuralgia. dyspepsia, melancholia, hay fever, coryza, lachrymation, ciliary neuralgia, conjunctivitis, tinnitus aurum, otitis, nasal obstruction, mouth breathing, impairment of the senses of smell, sight, taste and hearing.

If the mucous membrane is hypertrophied, the treatment is essentially surgical, and consists in the destruction and removal of the obstruction. Local applications to genuine hypertrophied tissue, in my hands, has been palliative only, and unsatisfactory. If there is simple swelling or turgescence of the membrane, we can accomplish a great deal by soothing antiphlogistic treatment, such as I have already mentioned. In removing the hypertrophied tissue I have succeeded best with chromic and acetic acid and the Jarvis snare.

In destroying or removing large hypertrophies, I use my concealed applicator—a description of which most of you have seen—or the Jarvis snare. Where the hypertrophy is small or covering the septum nasi, I use, with excellent results, the chromic acid applicator, designed by Dr. Chas. Sajous. In using chloro-acetic acid, especially in the posterior nares, Dr. Sajous furnishes us with a very ingenious and excellent applicator. It consists of two flat probes, shaped like Bosworth's in close apposition, their surfaces being so flattened as to render their contact perfect. One of the probes is fastened to the handle, and is furnished with a number of shallow holes, a distance of a half inch along the inner surface of its extremity, so that a drop of acid will be retained when the other probe is placed over it. The latter having free longitudinal motion, can be moved freely along the other, by means of a finger-lever, thus uncovering the acid-covered surface. Their broad ends being of silver, the acid does not affect them.

From one to six applications are necessary to hypertrophy of post. turbinated process; from one to three applications, an hypertrophy of ant. turbinated. Applications of chromic or acetic acid should not be made oftener than once or twice a week. In the interim, daily applications of carbolized vaseline (1 gr. to 1 oz.), by means of spray producers, should be made. This plan of treatment has given me satisfactory results, and the cicatrix is smaller than when the galvano-caustic is used.

I rarely use cocaine to the parts, before applying the acid, except in cases of marked hyperæsthesia. The pain caused by the acid is instantly relieved by the alkaline, two per cent. solution of cocaine as referred to. From six to ten weeks is the time usually required to successfully treat this disease, and even then the patient, unless very robust, should have a week or two of treatment every spring and fall for a year or two.

ATROPHIC CATARRH, (Rhinitis),

is the sequel of hpyertrophic rhinitis, and is characterized by abnormal patency of the nasal chambers, a sensation of dryness in the nostril and pharyngeal vault, strenuous efforts are being made to relieve this by blowing the nose. The sense of smell is obtunded or lost. The symptom which causes the most annoyance to the patient is the impure character of the breath. Thin scaly crusts of a greenish gray color, sometimes tinged with blood, are discharged through the nostrils, or hawked out of the throat. As the disease advances, these crusts become much thicker, and are discharged in the shape of flakes which present at times, a perfect cast of the surface which they cover. These scabs adhere tenaciously to the site of their formation, and are frequently removed with difficulty. The diminished vitality of the membrane, its deficient blood supply, and the absence of the lubricating glands, are obstacles which are overcome with difficulty, and require time and patience to influence. (Sajous.)

Resorcine, five grains, to vaseline, one ounce, sprayed into the anterior and posterior nares, has afforded me excellent results. If the secretion is very abundant and hard to remove, 5 to 10 gtt. of boro-glyceride, added to resorcine and vaseline, softens the crusts, stimulates the mucous membrane, thus aiding in the cleansing of the cavities.

If there is an unpleasant odor to the breath, due to the decomposition of the crusts of mucous in the cavitities, it is immediately destroyed by the application of resorcine. I use it in the strength of five to ten grains to the ounce (by volume) of vaseline. "It is an antiseptic and a stimulant, and, in view of its greater solubility, its almost imperceptible odor, its less toxic and irritant properties, it is superior to carbolic acid in the treatment of this disease."

If the crusts cannot be removed by means of the spray, our next best method is the cotton covered nasal probe, with which each crust should be carefully wiped off, after which a thirty or forty per cent. solution of glacial acetic acid is applied to the suppurative area. This checks the suppurative process. The patient should use daily, or thrice daily if the secretion is very abundant and the crusts form rapidly, a mild, stimulating alkaline solution. The following modification of Dobell's solution is the one I usually prescribe:

℞	Sodæ bi carb.	
	Sodæ bi bor,	āā ʒss.
	Listerine	℥j.
	Aquæ destil.	℥v.

M. Ft. sol.

This is to be used with the atomizer. The magic atomizer, No. 25, is the best instrument for the purpose I have seen. The atomized fluid can be thrown into the anterior and posterior nares. As the secretion lessens in quantity and becomes thinner, the cleansing solution (in atomizer) should not be used so frequently.

It is gratifying to be able to report that the profession is rapidly discarding the harsh methods of treating diseases of the nasal cavities; laying aside the post-nasal syringe, swab and douche, and is adopting the mild and non-irritating method. Having had both methods used on myself, and having used the method which I now advocate for six years, and carefully noted the results, I am thoroughly convinced that this is the best now shown, and the most rational.

In conclusion, I desire to emphasize the three indications, or objects, of the local treatment of diseases of the nasal and pharyngeal cavities:

First, non-irritation;

Second, thorough cleansing of the diseased surface, with sufficient force to remove the morbid secretion;

Third, medication and protection of diseased tissue without irritation of healthy tissue.

Thus far I have only spoken of local treatment; constitutional and hygienic treatment are not to be neglected, as nine-tenths of the cases of chronic disease of the nose or throat not only require local measures, but also the most careful constitutional and hygienic treatment.

◆

LONG RETENTION OF CANULA AFTER TRACHEOTOMY.—Dr. Souchon reports in the *New Orleans Medical and Surgical Reporter*, of July, a case of very considerable interest.

Dr. S. made a tracheotomy on a child four years old, for œdema of glottis. The child made a good recovery, and on the ninth day after the operation the canula was removed. Immediately the breathing became labored and the face cyanotic. The tube was at once reinserted and the bad symptoms disappeared. After waiting ten days longer another attempt was made to remove the tube when like symptoms reappeared and the canula had to be at once replaced. Later on a third attempt was made with like results. It was fully three months before the tube could be left out with safety, and then there was found to be no alteration in the voice.

ÆTIOLOGY OF PRURITUS PUDENDI.

By E. S. McKEE, M.D., Cincinnati.

The author in a paper before the Cincinnati Academy of Medicine, Sept. 20, 1886, on the subject of pruritus pudendi, disposes of that moot point, the ætiology, as follows:

Predisposing causes: — Different diseases of the neighboring parts, vulva, vagina, urethra, uterus, etc., pregnancy, general depreciation of the health, indolent, luxurious and enervating habits, syphilis, gouty and rheumatic, lithiatic, neurotic, diabetic, tubercular, lymphatic, asthenic tendencies, Bright's disease, the menopause.

Exciting causes: — Irritating discharges from leucorrhœa, especially uterine, the flow of the menses, cancer, incontinence of urine, diabetes, gonorrhœa, disease of the urethra, bladder and kidneys, strongly acid or alkaline urine, irritating discharges, local inflammation and irritation of vulvitis, vaginitis, congestion, eruptions, herpes, eczema, erythema, scabies, parasites, pediculi pubis, oxyuris vermicularis, ascarides, masturbation, venereal warts, urethral caruncle, want of cleanliness, sexual excitement and erection of the clitoris.

It is also laid to a general wear and tear of the nervous system. Irritating matter is carried to every part of the body by the blood. Pain is elicited at certain elective points, one of which is the vulva. In some obviously inflammatory cases it is hard to say whether the neurosis or inflammation predominates. In many of the most painful of these disorders there is no obvious inflammation, and in others when inflammation is obvious enough, the pain, though generally troublesome, is more endurable. Those cases which generally occur in women about the climacteric period are found generally in those who have a tendency to obesity, and who often have eczema. It is frequently found in those young women who sit much and who are subject to emotional and other centric nervous influences. Barnes says: There must be exaggerated centric irritability as well as an excentric irritation to produce marked forms of pruritus. This is why it is so marked in pregnancy. Many obstetricians confirm the observations of Mc Clintock, that pruritus vulvæ is one of the earliest symptoms of cancer of the uterus.

A VERY PECULIAR CASE OF IRITIS.

By C. W. Tangeman, M.D., Cincinnati.

During the month of July, Mr. Mc. made application at Dr. W. W. Seely's clinic for the relief of an eye trouble. It had been diagnosed a "cold" and had existed for three weeks.

Character of the pain complained of: quite severe at night over the affected eye and that side of the head, and the appearance of the eye itself rendered the diagnosis quite easy. The history obtained from the patient showed that we had to deal with a specific iritis which had developed in due time after the primary lesion.

The use of a four-grain solution of atropine instilled into the eye every two hours demonstrated the existence of a large number of adhesions between the iris and lens which were very persistent. Hydrarg. chlor. corros., in connection with iodide of potash made up the constitutional treatment, under which the patient gradually improved, the disease running the course of an ordinary syphilitic iritis. During this time the patient was not exposed in any manner but took the best care of himself. The atropine solution was employed but once a day now, since but little redness remained in the eye. About this time the second eye became involved in an acute attack of iritis which was very painful. The pupil, though reacting very sluggishly to the stimulus of light, dilated admaximum under atropine. Pain was the most prominent feature of the case now, it coming on about 2 o'clock in the morning in distinct exacerbations.

From the distinct periodicity and regularity of this symptom the mercurial medication which had been carried on to its utmost extent was suspended and large doses of quinine ordered to be taken during the latter part of the evening. The only effect noticeable was to produce intense ringing in the ears and fullness of the head. At this stage of the disease the patient complained some of pain in his extremities. Acting on this suggestion, two drachms of salicylate sodæ was administered in twenty-four hours, with the effect of an entire disappearance of pain. In the course of three days the salicylate was suspended and the pains returned, to disappear just as promptly when the medicine was again given. There was not a particle of doubt but what two distinct causes were active in this pathological process. The eye first involved yielded promptly to specific treatment, while the one last involved was only aggravated by it, but yielded to salicylate of soda. The process was so separate and distinct that one might have thought the two eyes belonged to different persons. The local treatment should always be kept up no matter what the cause of the iritis may be, or what constitutional remedies are given.

393 Elm Street.

◆

STRICTURE OF RECTUM.—Mr. Harrison Cripps (in the *Lancet*, Sept. 4th) narrates the following case that came under his observation at the St. Bartholomew's Hospital: J. B., æt. 48, quite well until eight months ago, when he began to be troubled by a fullness of the abdomen after eating. He then had periods of constipation alternating with diarrhœa. For the last two months he had had no motion at all from his bowels, but there was a slight discharge from the anus sufficient to stain his linen. He had felt pretty well until two weeks before, since which time he had been in bed. He had vomited once or twice, the vomit being sour but not offensive. The abdomen was much distended, measuring forty inches around the umbilicus, and had a doughy feeling. Examination revealed a fibroid stricture of the rectum, allowing only the passage of a No. 8 soft catheter.

The stricture was divided backward in the median line, and a large quantity of fecal matter scooped and washed away. During the next fortnight enormous quantities of feces oozed away so that the abdominal girth was reduced to thirty-four inches. The patient made a good recovery.

RESPONSIBILITY OF DRUGGISTS.—A Montreal man lately sued a druggist for damages for having been deprived of work for several weeks in consequence of taking poison sold him by mistake. The error was caused by the wholesaler, who had labeled the package wrongly before selling it to the druggist. The court held, however, that the druggist should have verified the contents of the package, and gave judgment for $200 and costs.—*Medical News.*

A PROPER GRATUITY.—A gratuity of $50,000 has been granted from the Bavarian Civil List to the widow of Professor Guden of Munich, who perished with the late King of Bavaria in the lake at Castle Berg.—*Lancet.*

EDITORIAL.

A. B. THRASHER, M.A., M.D., - - Editor.

BOSTON MEDICAL ETHICS.

In the conservative city of Boston there has been a gradual letting down of the barriers between the so-called "Regulars" and "Homeopaths." Last year Dr. Wesselhoeft, a prominent homeopathic physician, lectured before the conservative Boylston Medical Society, and this year Dr. Bowditch returned the compliment by lecturing before the Homeopathic Society. These lectures were high-toned and courteous and well calculated to overcome much of the petty prejudice which still exists on both sides.

Dr. Bowditch said:

* * * "We are *all* members of a profession which, when regarded in its true light above the plane of party, strife and mere selfish gain, I regard as the finest and noblest of all, and the feeling grows stronger within me with each year of practice. There is that in it far above the mere desire and ability to cure disease—that which can soothe all regrets for possible failure and disappointment in our daily work—I mean the power of human sympathy; the power that bids the young mother silently and gratefully press the hand that helped her during her hours of trial; the power that impels the dying man at the very last, to turn to him who, though powerless to save, yet by a word, a look, a touch of the hand, gives strength and courage to one just passing to that 'undiscovered country from whose bourne no traveller returns.' In the midst of discord and disappointment let us keep this thought before us, gentlemen, and at the end, perhaps, we may be permitted to see our past life, as it were, stretched before us, and feel that we have done our small share toward making our chosen profession what it should be—a blessing to all mankind."

Such sentiments are evidence of a broad culture. They will do much to do away with narrow sectionalism. To believe in the dogma *similia similibus curantur*, or to have a vindictive hatred of all who do, alike evidences the narrow mind.

THE AMERICAN RHINOLOGICAL ASSOCIATION. — The following are the subjects of some of the papers (with the authors' names and addresses) to be read at the fourth annual meeting of the American Rhinological Association, to be held at St. Louis, Mo., Oct. 5th, 6th and 7th, 1886.

Address to the Association, by the President, A. DeVilbiss, M.D,, of Toledo, O.

A Mixed Form of Atrophic and Hypertrophic Catarrhal Inflammation (heretofore undescribed), and its Treatment. By P. W. Logan, M.D., of Knoxville, Tenn.

Thoughts Relating to the Naso-pharyngeal Tract. By J. W. Fink, M.D., Hillsboro, Ill.

The Future of Rhinology. By Carl. H. Von Klein, M.D., of Dayton, O.

Necrosis of the Nasal Bones. By H. Jerard, M.D., East Lynne, Mo.

New Methods in the Treatment of Catarrhal Inflammation of the Nose and Throat, Including Diphtheria, etc. By H. Marks, M.D., St. Louis, Mo.

Treatment of Pruritic Catarrh (Hay Fever). By Thos. F. Rumbold, M.D., St. Louis, Mo.

Colds in Very Early Infancy; how Taken and how Prevented. By F. H. Hendrix, M.D., St. Louis, Mo.

The Importance of Early Recognition and Treatment of Naso-Aural Catarrh. By N. R. Gordon, M.D., Springfield, Ills.

The Use of Chromic Acid and Tri-chloro-acetic Acid in the Treatment of Hypertrophies of the Pharyngo-Nasal Cavity. By O. F. Brown, M.D., Lexington, Ky.

The Use of Cocaine in the Treatment of Diseases of the Nasal Cavities. By J. A. Stucky, M.D., Lexington, Ky.

Is Hay-Fever, so-called, a Disease *per se?* By J. P. Mathews, M.D., Carlinville, Ill.

Scarification in Nasal Hypertrophy. By A. G. Hobbs, M.D., Atlanta, Ga.

The Influence of Chronic Rhinitis on the Conjunctiva of the Eye. By Frank M. Rumbold, M.D., St. Louis, Mo.

Title of papers from applicants for Fellowship:

Chronic Naso-Pharyngeal Catarrh as a Cause of Neurasthenia. By John North, M.D., Keokuk, Iowa.

Oleate of Quinine in Nasal Catarrh. By Jno. D. Simpson, M. D., Bloomington, Ind.

Importance of Constitutional Remedies in the Treatment of Chronic Catarrhal Inflammation of the Upper Air Passages. By H. B. Logan, M.D., St. Louis, Mo.

Treatment of Acute and Chronic Inflammation of the Superior Respiratory Passages. By W. G. Lipes, M.D., Toledo, O.

Remarks on the Neglect of the Use of Emetics in the Treatment of the Diseases of the Throat. By Wm. A. McMurray, M. D., St. Louis, Mo.

Other papers are promised, but the subjects have not yet been given to the Secretary.

There will be a full display of instruments and electrical apparatus.

The prospects of a large attendance by physicians from distant states are very good.

The meetings will be held in the rooms of the Board of School Directors—the place of meeting of the St. Louis Medical Society—Public School Library Building, Southwest corner of Chestnut and Seventh Sts. Entrance on South side of Chestnut street.

All information concerning membership, etc., will be given by the President, A. DeVilbris, Toledo, O.; or by the Secretary, or by the Chairman of the Committee of Arrangements, Dr. H. F. Hendrix, cor. Jefferson ave. and Biddle st., St. Louis, Mo.

The full Programme will be ready to mail to any address on and after the 23rd of Sept., on application to any of the above officers.

P. W. LOGAN, M.D., *Sec'y*,
Knoxville, Tenn.

MIAMI MEDICAL COLLEGE.—Dr. Dan Millikin of Hamilton has been given the chair of Medical Chemistry in the Miami Medical College. It is needless to say that whatever Prof. Millikin undertakes he will do.

CINCINNATI COLLEGE OF PHYSICIANS AND SURGEONS.—Dr. Giles S. Mitchell has been elected to the chair of Pathology, and Lecturer on Clinical Gynæcology at the Cincinnati College of Physicians and Surgeons. The Cincinnati College is to be congratulated on the acquisition of a gentleman so thoroughly qualified and so well thought of by the profession in general as Dr. Mitchell.

CLERGYMAN'S SORE THROAT. — The etiology of clergyman's sore throat has always been obscure. Lawyers and lecturers who do an equal amount of speaking are not so much affected.

Dr. Thomas Whipham has recently offered an explanation which may assist in clearing up the etiology and at the same time be of great value in the way of prophylaxis.

He suggests that the trouble may arise from the position which is almost invariably assumed by the clergyman in speaking. He says that position is usually with the head bent forward, thus compressing the vocal organs and causing an unnatural irritation in the pharynx. This position, he says, is due to the relative positions of speaker and audience. The preacher is generally above his audience, and to face them he must look down. On the other hand the lawyer on addressing the court or jury is below them, and must speak with head well back. So also with the actor.

There may be something in this theory, and if so, a radical change in the construction of churches should be the result.

MEDICAL DEPARTMENT OF THE CINCINNATI UNIVERSITY. — The question of the establishment of a medical department in the Cincinnati University has been repeatedly before the Board of Directors. Now, however, there are prospects that such a department will be actually established.

If this means that there is to be added one more to the present number of Cincinnati medical colleges, we question the wisdom of the movement. If it means that there is to be a consolidation of two or more of our colleges for the purpose of forming one which shall unite the strength of all, then it is a consummation devoutly to be wished.

Such a college, with a faculty complete in every department, and a standard of scholarship as high as the highest, should have the hearty support of the profession of this city.

THE conditions for getting a Doctor's degree in the Berlin University will be found good reading by the American medical student.

◆

MISCELLANEOUS.

THE UNIVERSITY OF BERLIN.

REQUIREMENTS FOR GRADUATION.

The conditions for promotion to the Doctorate of Medicine, Surgesy, Midwifery, at the Royal Frederick William University, in Berlin, are as follows:

1. Candidates must have studied medicine at least four years in one or more regularly constituted universities. Universities and medical colleges abroad are deemed equivalent to the universities in Germany.

2. Candidates under thirty years of age who have not matriculated at this university, or who have left previously to their application for promotion, must matriculate again. This can be done free of cost. Both these and matriculated students of this university must, before making application for promotion, take out a preliminary certificate of having left, and will not receive the real certificate until after promotion.

3. The candidate has to make application to the Dean, handing in at the same time the documents mentioned under 1 and 2. He has then to pass a written and verbal examination before the Dean before being admitted to the *examen rigorosum*. The verbal examination is generally conducted in German or Latin, and extends to all branches of medicine. At the written examination an *ex tempore* essay must be written, without any assistance, in a given time.

4. After the preliminary examination the Dean lays before the Faculty the documents having reference to the personality and the course of studies of the candidate, the judgment respecting the preliminary examination, and the essay composed thereat. Should that body decide for admission, the Dean will appoint as early a time as possible for the *cxamen rigorosum*.

5. The *examen rigorosum* takes place before six members of the Faculty, is verbal only, and is conducted at one sitting, each of the examiners questioning the candidate for a quarter of an hour. No branch of medicine and surgery is excluded. It is generally held in German, but, if necessary, in Latin. If a candidate be rejected, six months must elapse before readmission.

6. After this the candidate must present a German or Latin dissertation. The essay must be entirely original; and the candidate must declare on oath in writing that he has composed it entirely himself. If the manuscript be pronounced good by the Faculty, he will have to get printed at his own expense (about 85 marks), by a certain printer, a prescribed number of copies. It must consist of at least two quires, and give evidence of a good scientific knowledge. To this must be annexed a brief *curriculum vitæ*, and at least three theses approved by the Dean.

7. After this follows the public discussion in the Aula of the University. The discussion has reference both to the dissertation and to the theses. Next, the opponents chosen by the candidate, who must be at least three in number, divide on the subject. Their names must appear on the title-page of the dissertation. Afterwards, anyone belonging to the University is at liberty to oppose. The candidates and the opponents must be dressed in black. The discussion is either in German or in Latin. The Minister of Education may allow the use of another language, and may also dispense with the discussion.

8. After the discussion is ended, the oath-taking and promotion of the candidate as a Doctor of Medicine, Surgery and Midwifery takes place. After the ceremony of promotion is completed the Dean delivers the diploma to the newly created doctor, who inscribes his name in the book of the Faculty. The expense of making out the diploma (15 marks) is borne by the candidate. A copy of it is fixed on the blackboard of the Faculty, and a certain number of copies are delivered to the Registrar of the University for distribution. Promotion *in absentia* can on no account take place.

9. 440 *reich marks* must be paid to the Dean as fees for the Degree of Doctor in Medicine, of which 221 *marks* must be paid on application, and are forfeited after the *examen rigorosum*, if the candidate be unsuccessful. The second portion (204 *marks* for the Faculty, and 15 *marks* for the University library) may be paid either at the same time with the other, or within the period between the *examen rigorosum* and the promotion. In addition the candidate has to pay expenses of printing the dissertation and diploma.

10. The shortest time in which the whole of the proceedings for obtaining a doctor's degree can be gone through is ten days. In this case, however, the dissertation must be delivered ready for

printing to the Dean at the first application, and the other business of the Faculty must be such as permits them to proceed at once to the examinations.—*London Medical Record.*

SCIATICA TREATED BY GALVANISM.—Dr. W. E. Steavenson, (*Lancet*, July 17th,) reports sixty cases of sciatica treated by galvanism. Of these sixty cases he says:

"Thirty-seven have been cured; one had a return of sciatica and was cured a second time; eleven improved only; one did not improve; concerning nine, I am uncertain as to the result: and two are still attending the hospital. Of those cases that recovered, three were cured with one application, two required two applications only, and seven cases were galvanized four times each, two were galvanized five times, one case required six times, four cases seven times, five cases eight times, one case nine times, four cases ten times, two cases eleven times, one case twelve times, one case fourteen times, and three patients came fifteen times before they were satisfied that they were cured; one patient escaped my observation and managed to get one or the other of the students to galvanize him twenty-five times before I stopped his coming; he had been free from sciatica for several weeks.

Of the cases which were not successful, one patient was, after death, discovered to have extensive necrosis of the ischium, with a sequestrum of dead bone. Another, a lady, was, at the time, suffering from some mal-position of the uterus, which was tilted over onto the side in which the pain was felt, and no doubt exercised some pressure on the roots of the nerve. Although in this case the sciatica was not cured, the patient was so much benifited that she was able to get about the house after eight applications. Before electricity had been applied she had been confined to her bed for five weeks. With regard to the second unsuccessful case, I can not well assign a reason for its non-improvement. The patient was a gentleman who had spent many years in the East Indies, and had suffered from dysentery and ague. He attended and was galvanized eight times, and as he was not then free from pain he did not care to continue the treatment. He tried several remedies afterward with the same unsatisfactory result. Perhaps if he had persevered longer with galvanism he might have been cured, for several of the hospital patients attended as many as ten or fifteen times before they were quite relieved. But there is more difficulty in obtaining the prolonged attendance of a patient who has to pay for each application, than of one who gets his treatment gratuitously."

THERAPEUTIC ACTION OF CHLORIDE OF SODIUM.—Dr. Branch's experiments on the action of common salt are given in the *Medical Record*, July, 1886.

"The blood, the saliva and the urine show a notable increase in the proportions of salt a few moments after its ingestion. Its effect on digestion is not only to augment the secretion of the gastric juice but to increase its acidity. After taking ten grammes daily, more than the usual quantity, for two months, the number of blood corpuscles was found to have increased, with a diminution of the albumen and watery constituents of the blood. The excretion of urea is increased, either owing to better diffusion or to acceleration of organic combustion. With ten grammes daily, in addition to the ordinary consumption of salt, the amount of urea was augmented to the extent of four grammes. Although certain advantages appear to follow a slight increase in the quantity of salt taken, an excess is certainly injurious. In one case death followed the ingestion of 500 grammes of sea salt. This toxic effect, however, has been denied. Deprivation of the ordinary ration of salt is rapidly followed by general feebleness, albuminuria, and anæmia. The condition likely to derive most benefit from a course of treatment with chloride of sodium is struma, but anæmia and tuberculosis are also improved. Pidoux recommends phthisical patients to eat largely of salt at meals. Goats' milk, rendered saline by the addition of 12 to 50 grammes of salt to the diet of the animal daily, is highly spoken of. Bouchardat has remarked that well-salted meat diminishes the thirst of diabetic patients to some extent, and lessens the excretion of sugar. In the form of baths its good results are well known in the treatment of chronic rheumatism, gout, gravel, and biliary calculi. Several observers have seen malarial fever arrested by doses of salt varying from ten to fifteen grammes. In solution it has been recommended for intravenous injection for cholera, and to destroy *oxyuris vermicularis* in children. The effect of salt is antidotal to nux vomica and curare, and to lead and silver salts. The necessity of avoiding the ingestion of salt in any form for some hours after the administration of calomel is, or should be, well known."

GONORRHŒA FROM RECTAL COITION.—Dr. Randolph Winslow reports in the *Medical News*, August 14, 1886, a curious epidemic of gonorrhœa. It occurred in an institution near Baltimore where a large number of boys were collected. Investigation revealed that sodomy had been practiced to some extent in the institution, and the gonorrhœal virus was supposed to have been thus introduced. A boy who was on a leave of absence contracted gonorrhœa from a girl. On his return he cohabited with another boy, communicating the disease to his rectum. This boy in granting favors to other friends, caused a general spread of the disease. Ten cases of undoubted gonorrhœa were known to have been treated. In two cases where buggery was admitted the rectum was found to be red, painful and inclined to bleed. These cases seem to conclusively prove that gonorrhœa of the rectum may exist.

A NEW DANGER IN OVARIOTOMY.—The dangers of spraying have hitherto been confined to the women operated upon, and, owing to the greater skill which has come from the rapidly increasing experience of many operators, these have been growing less and less. But now it is the operator who is incurring the greater risk. Two surgeons in Liverpool have recently exposed themselves to the vengeance of the irate husbands of their patients. One of these aggrieved individuals has sued a surgeon for damages for unsexing his wife, and the other has sent the author of his woes a challenge to fight a duel. (*N. Y. Medical Record.*)

FISH AS AN INVALID DIET.—Dr. J. Stewart Nairne reports in the *London Lancet*, Aug. 28th, a number of cases in which fish had been used as a diet for the sick with very bad results. Careful observation finally led him to believe that it was not so much the fish as the way in which they were cooked. When boiled or fried they acted very badly; but when steamed they were eaten with benefit.

CHLORODYNE HABIT.—The *British Medical Journal* reports three cases of chlorodyne habit with one death, due to continued overdosing with the mixture.

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, October, 1886. No. 1.

DENTAL DEPARTMENT.

DENTISTRY IN THE YEAR 2186.

(As Forecast by Sanguinis.)

"There will be neither delay nor inconvenience, Miss," said the dentist, as he applied the delicately perfumed lotion to her gums. "Painful?" Oh no, not in the least. We never hurt people now-a-days. We've got way beyond that. I now take up this little galvanic excising-saw and make free incisions, thus and thus; now I use gentle traction and out slides your lower jaw with the teeth attached, as snug as a whistle, metaphorically speaking. Having previously selected a *papier mache* substitute of proper size and shape I slide it into your mouth, and there we are."

"Why doctor! how perfectly delightful! I feel already that I shall not in the least miss my own teeth."

"I am sure you will do very well with these," said the dentist complacently.

"Now about the filling, doctor. What material will you use for that?"

"Filling? did you say, Miss? The scientific dentist of the present day does not fill teeth. We do far better than that. The wonderful reparative powers of Nature have become to an extent hardly dreamed of three centuries ago, the dentists most powerful and obedient adjuncts,—ahem. The course which I shall pursue with your jaw may be briefly outlined as follows: Repair with me (in imagination, of course), to the barn-yard. There struts in august supremacy a fowl of the order *gallinæ*, of the family *phasinidiæ*—in short, a rooster. For months he has subsisted on carefully sterilized food, the object being to eliminate from his system the steathily lurking *micrococcus*, the deadly *bacillus anthracis*, the venomous *spirobacterium*, *et hoc genus omne*. Having previously extracted all the decayed or unsightly teeth from your jaw, and placed in the alveolar sockets the germs of the new teeth to be produced, we bind the cut surfaces of the jaw to the freshly scarified comb of the cock. Now you may call in two weeks and we will be prepared to re-insert your jaw."

"Will new teeth grow, doctor?" asked the lady in amazement.

"Will they grow? I should say so."

"And are they exactly like the other teeth?"

"In appearance, yes. But they are vastly superior in density. In fact they are so extremely hard tnat lapidaries are beginning to use them for cutting diamonds. A hardware merchant told me the other day that the nut-cracker trade had declined fifty per cent. within the last year or two, owing to the improvement in people's teeth. But while the teeth grow harder and harder, the poor roosters suffer, — extracts all the phosphate of lime from their systems and leaves them tender as spring chickens. All the cheap boarding houses are buying dentists' roosters in preference to pullets."

"How perfectly delightful!" exclaimed the lady, selecting another victim from her caramel box. "Well, I will be going now, if you are done for the present."

"Good morning, Miss. Now, sir, I am at your service next."

"Doctor, I am introdncing to the profession—."

The dentist pressed a button that was designed to bring into play the patent "Bore Annihilator," but the stranger nimbly mounted a book case and proceeded with unruffled composure:

"This simple little instrument is called the 'Pocket-book and Bank Account Investigator.' Attached to the arm of your chair, it records on this little dial, in characters intelligible only to yourself, the exact amount of cash in your patient's pocket-book. Or by attaching it to the telephone you secretly ascertain the condition of his bank account. By the use of this valuable device, the dentist is enabled to preserve a conscience void of offense, since his charge for professional services need never exceed the patient's ability to pay. Dentists who have used it only a short time report their incomes doubled or even quadrupled. Now here is another equally useful appliance. Look at it. Isn't it a beauty? We call it the 'Artful Persuader,' or 'Patent Bill Collector.' Attached to the telephone it operates by rendering the delinquent totally oblivious of everything but the fact that he owes you a bill. By using extra cells in your battery it causes him to repeat aloud, without cessation, wherever he may be, the words: 'I owe Dr. A. seven dollars," or any other formula you may dictate. Sold only to dentists, by special agreement, and as a guarantee of security. Here is another, a patent *papier mache* jaw. Dentists complain that many times patients are so well satisfied with the artificial substitute that they never return for their own natural jaws, thus not only entailing loss upon the dentists, but discouraging the advancement of science. This artifical jaw is warranted to warp out of shape inside of three weeks. Inside of a month it will explode, visiting just retribution upon the offender. I leave these appliances for you to examine at your convenience, doctor. If you will now kindly restrain your patent 'Bouncer,' I will humbly withdraw by way of the back-yard fence. Meanwhile accept this trifle as a slight token of personal regard. It was thrown up by a laborer while excavations were being made to discover the site of the ancient city of Chicago. It was formerly used by dentists to extract teeth, and is called a forcep. Good day, sir."

"Good day, sir, good day," said the dentist blandly. "What an age of invention we have fallen upon!" he mused, as he shoved a cluster of *saccaharomyces-pastoriani* under his microscope and jammed a cork into a vial from which a *cladothrix-dichotoma* was struggling to escape.

◆

MAKING RETAINING POINTS.—Though many are now largely doing away with distinctive retaining points, a suggestion is applicable where they are indispensable. In highly sensitive cases, my Bonwill is run at its highest speed, and with a small stone-cut bur, kept for that purpose, and no other I sink the point desired by light recurring touches, selecting a location, if practicable, inside the loops of the dentinal fibrils at the periphery of the cavity.—Williamson, *Items of Interest.*

EDITORIAL.

SHALL PROFESSIONAL MEN ADVERTISE?

So far as the inquiry concerns the dentist, we might as well ask, shall we modify the code of ethics, since that instrument expressly states that "it is unprofessional to resort to public advertising—cards, handbills, posters, or signs calling attention to peculiar styles of work, lowness of price, special modes of operating, etc."

It will be noticed in the above extract, that minute specifications of the obnoxious features of public advertising are given. This is especially significant because it discloses the spirit which prompted the imposing of this particular restriction upon the profession. Good taste and common sense commend every item of the Article. It embodies opinions such as take shape spontaneously in the minds of all men of refined instincts, in or out of the profession. And yet, with this Article before his eyes, who for a moment supposes that the framers of the Code of Ethics meant to deny any one the privilege of making himself known as widely as possible, for professional attainments and skill? Improper ways of advertising have been defined: it has been left to each one in the profession to decide for himself how he may with propriety advertise. More than this, we hear the criticism, "Dr. A. is a good-hearted fellow, but he has no push, no get-up-and-go-ahead," etc., all of which seems to imply an unfavorable opinion of Dr. A. because he does not advertise himself sufficiently. Dr. B., who thus passes judgment upon a less prosperous brother, perhaps belongs to a class of those who advertise by such legitimate means as mingling in the best society of the community, driving a team of matched horses, attending a fashionable church, and all that. The conclusion seems to be that you may advertise, nay *must* advertise, to insure success, but you must not do it clumsily. You may do it too, in a way calculated to exalt yourself over a fellow-practitioner (in direct defiance of another provision of the Code), only you must use tact and discretion in putting him down.

The editor of the *Ohio State Journal* thinks that specialties in dentistry should be encouraged, and that the specialist ought to be allowed to advertise in the professional periodicals, at least. He argues the matter with much circumspection, as if conscious that his views are antagonistic not only to the strict letter of the Code, but to a time-honored, conservative sentiment prevailing in and out of the profession. Here is the extract to which we refer:

> "The genuine special practitioner ought to be allowed to give notice by means of the professional periodicals, at least. Our patrons seek us on account of their infirmities and misfortunes. Shall we force them, by a rigid interpretation of a code of ethics, to advertise these? Suppose the specialist confines his practice to the treatment of irregularities. Must a refined, sensitive, and *beautiful* young lady (except that her mouth is deformed) go along the streets and lanes of the city, like Wisdom in the Proverbs, saying to those she meets, Excuse me, stranger; but see how my mouth is deformed. Can you direct me to the man that will made me pretty?
>
> With present views, it seems the practitioner must wait and become wrinkled and gray, before his expert talents are recognized. And then, by the next year he will be regarded as *too old* to be reliable. There ought to be a remedy. The old gray squirrels enforce a code of ethics by which they retain the most pleasant parts of their practice, to the excluson of the younger practitioners. It seems to work well in the forests.
>
> But if any one despises quack advertising more heartily than we do, we shall drop our sentiments and adopt his."

His plea for the specialist seems to possess no features that would not apply equally to the general practitioner. Why may not any dentist who feels that he is qualified to minister in a *general* way to the wants of the suffering, advertise the fact? True, the editor above quoted limits his plea to an advertisement in the professional periodicals, but inasmuch as we cannot easily conceive of a respectable professional journal's publishing a "quack advertisement," we are forced to the conclusion that the editor of the *Ohio State Journal* has vaguely in mind something more than he expresses. It is hardly to be supposed that one meeting casually a *stranger* on the street, would expect him to be informed of what is published in a semi-private way in a professional periodical. This looks rather more like an appeal to the stranger's supposed familiarity with the advertising columns of the morning daily.

It is not to our interest, however, to make out an indictment on the charge of sheep stealing against any one, since we have for some time cherished designs of the same kind. A young man spends years of time and hundreds of dollars in preparing himself for a profession. When he finally opens an office and hangs out a sign [advertisement?] he perhaps ventures with some misgivings to insert a brief card in the daily paper. He seldom leaves it there for any length of time, as if suspecting that the impropriety of such a procedure assumes more enormous proportions with each repetition. Finally it is withdrawn altogether. He is presently rendered uncomfortable by the discovery that his sign is four inches larger each way than old Dr. B's. So he substitutes a smaller and more expensive one. He concludes that advertising does not pay, so he devotes most of his time—leisure time we mean, of course—to boring his friends and acquaintances with fairy stories about his large and constantly increasing practice. He is secretly laughed at, but he keeps it up, and after a few years people begin to believe him. (This shows the value of judicious advertising). He puts on lots of style and gets deeply in debt, but if he is smart, (and young men with his amount of "push" usually are smart), he keeps the last stated fact strictly to himself. After years and years of this evading the letter and provisions of the Code, he begins to be really prosperous, but by no means as prosperous usually as people think. Still he gains the victory, and thanks the Lord that he never resorted to quack advertising.

Now, why should not this man or any professional man who needs patronage be allowed to keep a card in the daily paper the year round? He need not exceed the limits of good taste in wording his advertisement. Who doubts that it would be quite as effective as the druggist's or the architect's card? To a certain extent public sentiment confirms the professional man's aversion to advertising. At the same time, we question whether the popular verdict would not be that restrictions which operate practically to limit the field of the professional man's usefulness, have a tendency rather to belittle than to dignify him. It is possible that a general inquiry among professional men would reveal a pretty nearly unanimous opinion that the spirit of the Code does not prohibit anyone's inserting a simple notice in a daily paper or other periodical. This is altogether a matter of speculation, however. Such liberties with the Code are not unfrequent. Men who stand in the foremost ranks of the profession have been known to make use of the daily paper to announce their return from a vacation, or the removal of their office to another location.

Leaving out of view the question of privilege, some no doubt would hesitate to keep a card in a paper because of the very appearance of a lack of patronage. It may be then, that any proposed amendment of the Code of Ethics, in the way of granting more liberty in advertising, would only bring out more conspicuously a widely prevailing sentiment more powerful even than the published decree.

ERRATUM.

WE quite forgot to announce in the September number the closing of the first volume of the Journal. It was not perhaps important that attention should be called to the fact. It is, of course, sufficient cause for self congratulation to both the editors and the publishers of the Journal that it has been well received, and that its subscription list is growing even beyond expectation. The list of contributors to the dental depariment is hardly what we desire, but as the Journal grows in favor we hope for a larger share of the good things that ought to be bestowed impartially for the benefit of the profession. Meanwhile, we shall continue to supply selections of a character calculated to interest and instruct our readers.

A few words to contributors: Please do not incorporate in a letter to the editor an article for publication; make the article separate and complete in itself. There is no great art in doing this. If you wish to describe an operation, first recall all the details in order as you perform them, then write it out in plain, simple language. Then read your article as if it had been written by somebody else; this will enable you to judge whether your readers will fully understand what you mean. You may find it necessary to rewrite the entire article, in order to supply some point omitted. That is part of the discipline to which every writer is subjected. We particularly invite short contributions of a descriptive character. It is the little things which can be described in a few lines, that are often most valuable to the reader. Comparatively few of the longer contributions to dental journals would not be improved and secure a more general reading by being cut down a third or one-half.

OHIO STATE DENTAL SOCIETY. — The second annual meeting of the Ohio State Dental Society (reorganized) will be held in Toledo, O., beginning on Tuesday, Oct 26th, at 10 a.m.

F. H. REHWINKEL, *President*,
J. R. CALLAHAN, *Secretary*.

MISCELLANY.

THE NEW ANÆSTHETIC.

INQUIRY directed to Dr. J. E. Clark, M.D., F.C.S., of the Detroit College of Medicine, relative to the recently discovered anæsthetic, (the Raoul-pictet disinfecting fluid), elicits the following regarding its composition. It consists of one molecule each of CO_2 and SO_2, which under the influence of reduced temperature and increased pressure makes a chemico-physical composition represented by the formula CSO_4, or that ratio. Dr. Clark states that the chief objection to its use in dentistry must be the irrespirable and offensive odor of the anhydrous, sulphurous acid which is liberated on contact of the fluid with the atmosphere.

At the same time Dr. Clark writes that he is engaged in experiments in which he hopes to overcome this objectionable feature, and would be pleased to receive suggestions from any one interested. He adds an opinion "that compound gases exist which under the same or similar manipulation can be made available for the relief of pain incident to dental operations," and thinks here is a field for remunerative original investigation. [See August No. of this Journal].

LABORATORY HINTS.— After grinding the ends of teeth, sandpaper them, as it makes them smoother.

For polishing gold and other metals, drive a piece of pine into a lathe chuck, and then turn it to a point, with a pocket-knife. It is excellent for finishing backings and the palatial surfaces of gold plates.

Use small sized, soft brushes for polishing, as they retain the polishing material, coarse ones throwing it off.

An acid dish made of thick sheet lead is superior to any other for sulphuric acid, which is the only acid needed for metal plates. It can be easily formed with a mallet, over a wood form made for the purpose. Cut the lead so that a handle can be left on one side.

In soldering, have the plate clean, use plenty of borax, cut the solder in small pieces, and heat the whole plate, so that plate and backing shall be of uniform temperature before concentrating the heat on the solder. The melting point of the solder should be near that of the plate, otherwise before the plate is hot enough the solder melts, and rolls away from where it is laid.

Never use a lower carat than 18, even if your plate is 18.

There is no necessity at all for riveting pins; countersink the hole and if it is a little larger than the pin the better, and then the solder flows into it around the pin, whereas if the pin is riveted, the solder is prevented from flowing round it.

I prefer imesting the teeth as arranged on the plate, and then backing, as it saves one heating and considerable time. I round the end of the backing instead of making it square, and chamfer the edges.

After annealing a plate drop it into the acid, the surface being cleaned, you can see any base metal that may adhere in swaging.

There is such a thing as over-swaging a plate to be guarded against.—Haskell, *Items of Interest.*

DR. F. S. CASPER, of Austin, Texas, suggests the use of small napkins to cover the index finger while making examinations. He makes these napkins of soft-finished jaconet torn into rectangular pieces about three and one-half by four inches. They do not require to be hemmed. Add a little of some kind of delicate perfume, and keep constantly within reach. Apropos to our editorial on advertising, the observance of little niceties like this suggestion, is an admirable way of advertising. Fine operations in the way of fillings, or exceptional skill in making plates, may secure a fair patronage to the dentist who uses soiled napkins or dingy impression cups, but who can estimate the amount of his losses brought about by the stories his patrons circulate about his disregard of common decencies?—[ED.]

INHALER FOR ETHER.—It is well known that the less ether is inhaled to produce unconsciousness, the less disagreeable will be the after effects; and the less air inhaled, the easier and shorter will be the process of etherization. A good inhaler must have four good qualities: be of a convenient size and shape, economize ether and exclude air; be simple in construction, so that it may readily be cleansed; and cheap in price. A sponge will neither exclude air nor economize ether. A good one is, moreover, very expensive and difficult to obtain. Many inhalers in the market have their excellent points, but all expensive. After many experiments and unsuccessful attempts to obtain a satisfactory inhaler, I thought of the following device, and can recommend it as the best and most economical inhaler. Buy the small-sized bowl that the dentists use for mixing plaster in—the so-called plaster-bowl. It is made of soft, vulcanized rubber, and is about four inches in diameter, and three inches in depth. It is so soft that it will fit closely to the face, and exclude atmospheric air, and prevent the evaporation of the ether. Within this bowl place any cheap sponge of suitable size, and the inhaler is complete.—*Technics.*

HOW TO BUR A TOOTH CAVITY.—Strong pressure on the bur, and slow revolutions over sensitive dentine, and the same method carried from the margin of a cavity down deep toward a nerve, give unnecessary pain. Continued pressure on the bur generates heat in the tooth—one of the most disagreeable sensations to the patient. Consciousness of the patient that the bur is cutting its way toward a nerve is of itself painful, specially so when the cavity is deep. The painlessness of a swift perforation of the flesh by a bullet, or the swift stroke of a sharp instrument, gives a hint, in the right direction. As far as practicable in deep, sensitive cavities, place the bur at the bottom of cavity and cut outwardly, running the engine swiftly, then with light pressure pass rapidly over the parts to be excavated with moderately rapid intermittent strokes of the bur, when, if your instrument is sharp, no frictional heat will be generated, and the actual cutting will take place before the patient realizes it. -Williamson, *Items of Interest.*

REMARKABLE IMPROVEMENT IN THE MICROSCOPE. — Recent experiments have resulted in the successful production of a microscopic lens so powerful as to make distinguishable the one two-hundred millioneth part of an inch. The best microscopes in present use magnify to the extent of rendering distinguishable only the five-hundredth part of an inch. In other words, the new lens is 400,000 times as powerful as the old! The constituents of the new glass are fourteen in number, against six in the old. Boron and phosphorus are the principal ones of the new element.

BIBLIOGRAPHY.

THE AMERICAN SYSTEM OF DENTISTRY. In treatises by various authors. Edited by WILBUR F. LITCH, M. D., D.D.S., Professor of Prosthetic Dentistry, Therapeutics and Materia Medica in the Penn. College of Dental Surgery. Vol. I. Regional and Comparative Dental Anatomy, Dental Histology and Dental Pathology. With five hundred and thirty-seven illustrations, and six plates. Philadelphia: Lea Brothers & Co. 1886.

This work is evidently designed to compass the entire field of dental science and to include also much that pertains to the manual art of dentistry. The first volume, now before us, contains one thousand and ten pages of reading matter. The introductory chapters are devoted to general and special anatomy (of the head and face), the teeth of vertebrates and invertebrates, dental embryology and histology, and general pathology. Following these are treatises on dental caries, biological studies on fungi of the human mouth, pathology of the dental pulp, diseases of the pulp and their treatment, diseases of the peridental membranes, and abrasion and erosion of the teeth. The extensive range of subjects treated invites the attention of every dentist, whether he is interested in all that pertains to the science as regards what is theoretical and scientific, or merely in that which has a more direct and practical bearing on his daily practice. The treatises are by various writers eminent in the medical and the dental professions. The work will be complete in three volumes. We regret that space admits of only a brief notice. The sub-chapters on micro-organisms, neuralgia, caries, alveolar abscess, and others, are of a character calculated to interest every dentist who desires to keep abreast of the times.

INDEX TO THE PERIODICAL LITERATURE OF DENTAL SCIENCE AND ART. By J. TAFT, M.D., D.D.S., Professor of the Principles and Practice of Operative Dentistry in the Dental College of the University of Michigan; author of "Operative Dentistry." Philadelphia: P. Blakiston, Son & Co., No. 1012 Walnut St. 1886.

This is a book of reference for dentists. Its plan includes an index to the periodical literature of dentistry, an index to dental periodicals, and an index of authors. It gives a list of all home and foreign dental journals published since the year 1839, with the editors' names and other particulars. The index of dental periodicals which follows consists of an alphabetical arrangement of all dental subjects written about in dental or other journals, with the names of the journals and the authors' names. The index of authors gives the names of all contributors to dental literature, with the subjects treated, and is alphabetically arranged.

◆

MUCH OR LITTLE WATER IN VULCANIZING?—I noticed recently in one of our leading dental offices that in vulcanizing a case the boiler was filled nearly to the brim with water. If those who still follow that method would put but a half-dozen spoonfuls in a steam tight boiler, even placing something under the flask to keep it from the water, they may discover three advantages in the device: a tougher plate; absence of much disagreeable odor, and models and investments disintegrated. Give a little longer time for vulcanizing by this method. Those who offer new machines for accomplishing this purpose may not thank me for this suggestion.—Williamson, *Items of Interest.*

WHEN THE TEETH ARE SOFT and sensitive, and affected with white decay, we remove the softened portion of decay and fill with guttapercha or cement, leaving it so for several months before attempting to insert gold. Sometimes removing this temporary filling, shaping the cavity and refilling with cement for several months longer. The cause of so many failures with this class of teeth is haste in preparing the cavities and inserting gold, not allowing nature sufficient time to fortify. With the darker variety of caries this treatment is not necessary.—*F. M. Hamsher.*

ALVEOLAR ABSCESS.—If a portion of the root be amputated and patience be exercised, the tooth will be saved. In my own limited experience I have many times seen the root denuded, and after amputation the case got well. It is sometimes possible to distend a fistula by means of a sea-tangle net, or compressed sponge, till access can be obtained to the root. Then excise the abscess.—*Dr. Ames of Illinois.*

THE

CINCINNATI

Medical and Dental

JOURNAL.

Vol. II. Cincinnati, November, 1886. No. 2.

MEDICAL DEPARTMENT.

ICHTHYOL AND RESORCIN IN THE TREATMENT OF SKIN DISEASES.*

By A. Ravogli, M.D., Cincinnati, O.

For some years we accepted in the treatment of skin diseases several remedies of a local application, which at first were regarded as the greatest discoveries of the epoch. The remedies were chemically studied and then physiologically tried, so as to establish their pharmaceutical place and their application in therapeutics. You remember chrysarobin, which made its appearance in therapeutics under the name of chrysophanic acid and was considered as an infallible means for the treatment of psoriasis, herpes tonsurans, etc.; but for its mischievous quality of bringing about an extensive dermatitis is at the present day very seldom employed. From analogy alizarin was proposed as a substitute for chrysarobin, but the experiments were entirely without result. Pyrogallol, or pyrogallic acid, belonging to the same chemical category, next came under experiment, and you know that the results were found very satisfactory. Its action on the skin was found to be milder than that of chrysarobin, affecting only the diseased skin, and very little the healthy, with slight reaction. Psoriasis, lupus vulgaris, lupus erythematosus, etc., were by this remedy satisfactorily treated. Cases of poisoning by pyrogallol were mentioned: one by Neisser, and one by Vidal, with a fatal end, and two others terminated in recovery. This caused some dissatisfaction with the pyrogallic acid, so that to-day it is applied with some apprehension.

---

* A Paper read before the Academy of Medicine, Oct. 8th, 1886.

Two other preparations of the same category, ichthyol and resorcin, isomeric, have been lately proposed and tried in the treatment of skin diseases. Their basis is diphenol. Ichthyolic acid is an hydroquinon, obtained fron the sulphate of diazophenol boiled in water saturated with sulphuric acid, and is represented in the benzinic group. The salts resulting from the combination of ichthyolic acid with a basis, as ammonium or natrium, are found in commerce under the name of ichthyol.

It is interesting to group in a pharmaceutical class all these substances belonging to the same category, which applied therapeutically show some analogy in their action.

P. G. Unna (Dermathologishe Student, Hamburg, 1886) established a class comprehending all these substances under the name of *reducentia*, reducing agents, at the head of which he placed pyrogallol.

The action of these substances upon the skin must be considered according to the condition of the skin itself: 1, when the horny layer is intact; 2, when the corpus malpighi is exposed; finally, their action on the parasites of the skin.

In every remedy which we use in medicine we remark a difference of action according to the dose or the concentration of the solution, so that a remedy used as a simple astringent, in a concentrated solution produces a caustic action; furthermore, the method of its application changes its action, as when allowed to penetrate deeply into the tissue or when left only on the surface. This law, which we find constantly in pharmacology, has the same value for the reducent remedies which we are now considering.

When we apply to the skin a mild solution, e. g., 3 per cent. to 5 per cent., of pyrogallol, the first changes are seen in the epidermis and just on the horny layer, which becomes harder, thicker and dry. The epithelial cells exposed to the action of the remedy assume a brownish color, which, by continuing the use of the solution turn dark and are separated from the underlaying layer by desquamation. The cells of the rete mucosum meanwhile assume the properties of the horny cells, so as to take their place on the surface. The first action of the reducing remedy when brought in contact with the living skin can be considered as an induration of the epidermic tissue (*Verhornung*), which occurs in the tissue always when their oxygen is appropriated by the applied substances.

The same action of the reducing remedies which we have observed on the horny layer we must consider on the epithelium investing the sebaceous glands. Many times the cells, hard and dry by the action of the remedy, obstruct the opening of the glands, and pustules result.

When the application of the remedy is continued its influence is displayed in the underlaying tissue and the bloodvessels are next affected. Their calibre is diminished by a contraction of the small arteries, veins and capillaries. In erysipelas, erythema and acne rosacea we can see this action very easily, when the redness after a few applications disappears. This makes the remedy of great value, when we know from Conheim that stasis is the most positive effect of the inflammatory process. By reducing the calibre of the bloodvessels we diminish the stasis, and consequently we diminish the exudation and the resulting painful sensation. It is not yet easy to understand how this astringent action affects the bloodvessels. Unna believes that the same reduction which we can see on the epidermic cells of the horny layer and of the rete mucosum takes place in the endothelium of the vessels.

When by use of the reducing means we have diminution of the pain, we must infer that an action is also displayed on the terminal nerve filaments, which may be indirect, from the diminution of the stasis and of the exudation. In this way we have an explanation of the relief of pain which follows the application of these substances. Another perverted sensation exists in the skin as an organ of sensibility which we know as itching. The reducing substances in mild solution at times have the power of diminishing the itching sensation, at times have no such influence, in strong dose they are able to produce pain which takes the place of the itching sensation.

The substances of which we are speaking are all coloring matters, some of them are used in dying and scouring drapery. A coloring action is also exerted on the skin, and the brownish-red color produced by chrysarobin is very well known. Pyrogallol stains the skin a yellowish-brown, and resorcin in a yellowish-brown and red hue Ichthyol, too, when applied to the skin, leaves a yellowish-brown hue, like the sunburned skin. The color is strongly intensified by alkaline substances, and very probably the coloration of the skin is due to the alkaline salts contained in the epidermis. Acids diminish the color. When using pyrogallol or resorcin, if a salve with oxide of zinc is applied, it will produce an intense discoloration. It is singular that all parts of the skin are not colored by these substances in the same way. The palm of the hand is much more quickly and intensely colored than the skin of the legs; the legs more than the skin of the forehead; the hairs, too, are easily colored. It is remarkable that the skin is differently colored according to its healthy or unhealthy condition, and according to the different skin diseases. In psoriasis and in herpes tonsurans the spots are but little colored, while the surrounding healthy skin is intensely colored, just the opposite occurs in pityriasis versicolor and lepra.

When a strong preparation of pyrogallol is applied as a salve, from 15 to 20 per cent., the action is much more intense, and the horny layer of the epidermis is in a short time changed into a kind of parchement. The epidermis is raised by exudation in form of blebs, and we have blisters and suppuration. The loss of substance resulting from the action of these remedies so used is repaired very promptly by formation of good epidermis and the consequent scars are flat and regular. The normal tissues are not strongly affected by their action, but the colloid tissues are affected and destroyed. The resolvent action of these remedies on the scars and on the keloid is remarkable, which tissues being poorly supplied with blood vessels are nicely reduced under their action.

When the epidermis is no longer intact, the rete malpighi and the papillæ of the skin are exposed, the application of the reducing remedies has not the same effect as we remarked on the skin protected by its epithelium. In case of an eczema ruber, with the presence of excoriations, the application of one of these remedies produces pain, irritation, exudation and œdema of the skin. But, in case of lupus, of eczema chronicum of ulcers of the legs, where there is a layer of necrotic tissue on the surface, the application of the substances in question, also at first painful, cleans and hardens the surface and the young cells of the mucous layer of the epidermis take on a better development, and the surface heals. In a chronic eczema a salve containing some ichthyol will be useful.

The remedies of this class were found useful in the parasitic affections, and especially chrysarobin, proved very successful in the treatment of stubborn cases of herpes tonsurans. Cramoisy (traitement des teignes) tried to analyze the action of the antiparasitic treatment. He came to the conclusion that the antiparasitic remedy must not kill the parasite, but must produce a necrosis of the epithelial cells and consequently a desquamation. Therefore any substance capable of producing desquamation of the epidermis can succeed as an antiparasitic remedy.

We can easily produce desquamation of the epidermis by rubbing the surface with sand or with dust of pumice stone. If desquamation could only bring about the recovery of a parasitic affection, we ought to be enabled to cure pityriasis versicolor, a slight and superficial affection, by means of rubbing the surface with some sand or pumice stone. We do not succeed, and Besnier says that pityriasis versicolor is treated when the pumice stone is mixed with soap. But in this case we must consider the chemical action and the antiparasitic power of the soap. But if this can be said for pityriasis versicolor, which is the most superficial of all the parasitic affections, it cannot be applied to the others where the parasite vegetates deeply under the epidermic cells of the horny layer. Chemical influence is necessary which, in the same way as it attacks the epidermis, affects the parasite in its vegetative functions. After a few applications of a sulphurous, pyrogallol or resorcin salve in a parasitic affection, we see the epidermis accumulating in a kind of brownish crusts or scales, and after while when these are removed the epidermis appears clear and sound, and the disease is cured. In this case we find the desquamative action associated with the antiparasitic; the epidermic cells affected by the parasitic elements are attacked, and the parasite is deprived of its vegetative power and is removed together with the necrotized epidermis. We can not deny that in this treatment the remedy displays a specific influence on the cause of the disease, and by the action produced on the epidermis exerts an eliminative effect through which also the cause of the disease is removed by the consequent desquamation.

The remedies which we have under consideration—*reducentia*—have proved successful in the treatment of parasitic affections of the skin. Their antiparasitic action may be ascribed to their faculty of absorbing oxygen from the living tissues. Therefore the parasitic elements are deprived of their oxygen, and consequently their vegetative power.

After the above general considerations on the local action of the reducent remedies on the skin, we will limit ourselves to the application of ichthyol and resorcin, which are not yet so well known as the others.

We have seen that one of the most interesting actions of ichthyol is to produce a constriction of the caliber of the blood vessels, thus diminishing the stasis. Until now we have not had a remedy capable of this action, and it was therefore applied in every form of *acne rosacea.*

You know that acne rosacea has not always the same appearance, but sometimes it appears as a vivid, intense redness of the face produced by an arterial congestion, hyperemia, with tendency to eczematous eruption, and to the formation of small superficial pustules. At other times big, hard acne pustules are spread over the face on a bluish, livid congested surface. The horny layer is hard, thick, and the skin is not inclined to eczema. In both cases we can use ichthyol, but only in different doses. In the first case a strong mixture of ichthyol would cause an irritation and produce an eczema, as the skin is actively congested and is very easily inclined to inflammation. But a mild mixture of ichthyol, having its influence on the caliber of the blood vessels, is useful to diminish the stasis. Ichthyol as a mild dose does not deeply affect the epithelium, and in a short time we have a remarkable improvement of this affection. In the other case it is necessary to act more violently, and strong mixtures of ichthyol are required, so as to act on the thick epidermis and through it on the blood vessels for reducing their enlarged caliber. Some of the pustules are easily involved, and by resolution they disappear; some others pass promptly to suppuration, their contents are discharged, and the pustules heal up in a short time.

To the cases reported by Unna I have to add several cases from my own experience, among which I select the following.

Mr. B. W., aged 37, for several years has been annoyed with a stubborn case of acne rosacea. The gentleman never drank any intoxicating liquor, and the cause of the rosacea was to be found entirely in a chronic catarrh of the stomach, associated with constipation. He was under my treatment for some time, and by means of scarifications in the enlarged blood vessels, of opening the pustules, and different ointments he had a satisfactory result. Four months ago the redness was again very perceptible, new pustules were coming out, and the skin of the cheeks appeared hard and yellowish like parchment. I proposed to use ichthyol, which was prescribed in a salve:

℞ Natr. Sulfo-ichthyol, - gmm 5.00
Unguent. Diachyl. Hebra, " 25.00 M.

which represents 20 per cent. of ichthyol. The salve, spread over a piece of cloth, was applied at night to the face. In the morning, with a little sweet oil, the salve was wiped off, and after which, with ichthyolic soap, he washed his face. In a short time the pustules disappeared, the blood vessels were scarcely perceptible and the epidermis so hard and thick became smooth and soft. The patient has entirely recovered.

Ichthyol has also proved successful in cases of acne vulgaris. It is true that that in this affection several other remedies are in competetion with ichthyol, but from my experience it proved to be superior, as it is easily applied and can be used in association with other remedies without inconvenience. The application of sulphur very often produces irritation of the conjunctiva, and cannot be used with unguentum diachylon, as it stains the face.

Miss B., aged 23 years, had acne punctata et indurata of the face for some time, which was associated with a catarrh of the stomach. She was under my treatment for a long time, and I succeeded with the ordinary means of bringing about a recovery; but the skin in some places remained red and hyperæmic, and, once in a while, showed some pustules. In the month of June last she returned with an eruption of new pustules on her cheeks, on the forehead and on the chin. I wished to try ichthyol, and I prescribed an ointment containing five per cent. of ichthyol to be applied at night. After some applications the pustules began to lose their color, to diminish in size, showing a small, dark brown crust in their middle, and in about three weeks her face was entirely clear.

I. B. M., a boy 12 years old, showed a disseminated acne all over his face; the pustules were not very large, but were numerous. His health had been good, but for some time he showed gastric trouble. An ointment with 10 per cent. of ichthyol was prescribed to be applied in the night. After one week, by using this application, the pustules were dry, surrounded with a small dark crust, and slowly disappeared.

Prof. Unna recommends the use of ichthyol also internally, from ten to fifteen drops a day. I, too, prescribed ichthyol for internal use, but few patients could bear it on account of its nauseous smell. In the case of Miss B. the internal use of ichthyol brought again troubles of the digestion, and we were obliged to stop it. Several of our patients under the internal use of ichthyol complained of a stubborn constipation.

We have already remarked that the use of ichthyol on an excoriated surface produces irritation, and in cases of eczema rubrum it is not applicable. We have, however, some kinds of eczema where it has proved satisfactory. Eczema which comes suddenly, as a red surface with formation of small vesicles, or the eczema which is called erythematosum ; both forms easily disappear, leaving a slightly scaly surface, but relapses follow very frequently. If we enquire into the cause of these cases, we find a great difficulty in assigning any, and it seems to-day that such forms of eczema are due to the condition of the vaso-motor nerves, and may, therefore, be considered as eczema nervosum. In these cases ichthyol gave us good results, as appears with the following case:

Mrs. L. T., aged 52, shows an eczema on her forehead and on both the ophthalmic regions, with swelling of the eyelids, burning and itching sensations accompanying the affection. My friend, Dr. G. Zinke, had the case under treatment and he called me in consultation. The eczematous eruption made the lady unhappy on account of the frequent relapses. Ichthyol was used internally in the dose of five drops twice a day in some beer so as to disguise the unpleasant taste, and a mixture of ichthyol in glycerine was used locally. After two weeks the eruption had entirely disappeared and has not since returned.

There are other cases of eczema exceedingly stubborn where the cause could not be found by F. Hebra. Eczema, which begins usually in the form of intertrigo, and it seems to-day that the cause must be found in the presence of parasitic elements. Hebra, jr.,* called the attention of the dermatologists to these affections. He found small, brilliant, roundish elements on the epidermic cells, apparently like the elements of pityriasis versicolor. He could not find the organs of fructification, but from analogy and from the results of an anti-parasitic treatment, now it is believed that their cause is a parasitic one. In several of these cases ichthyol has been employed by Unna with a satisfactory result, and in our practice we can to-day support his views. In cases of eczema of the head, with furfuraceous desquamation, the idea of presence of parasites is now maintained and we could prove the efficacy of ichthyol in these cases.

---

* Über eine eigenthümliche Dermatomikæ. Wien, 1881.

Miss L., from Paducah, Ky., for two years has been affected with eczema capitis. The itching sensation was so unbearable as to prevent her sleep. The lady showed patches of eczema on her scalp covered with furfuraceous desquamation, small pustules, some excoriated spots were scattered all over her head, the skin was red and in some places infiltrated. Ichthyol was prescribed in the following formula:

℞.	Ichthyol, - - -	grms.	5	
	Aq. Rosar, - - -	"	10	
	Glycerine, - - -	"	10	
	Alcohol, - - - -	"	60	
	Ol. Bergamott, - -	gtt.	5.	M.

For external use.

After the second application the lady was relieved from the itching sensation, the skin was no more so irritated, the scales no more so abundant and the pustules were covered with a brownish crust. In a few days the lady could return home without further trouble. I recommended her to continue the application of a slight mixture of ichthyol once a day for one week longer so as to prevent relapse.

In herpes tonsurans, especially of the body, we found ichthyol a desirable remedy. Its mild action produces a slight desquammation of the spots, the redness disappears, and in a short time the skin returns to its normal condition.

Mr. H. H. T. for several years had been troubled with herpes tonsurans of the body (erythematosum) which from one region spread to another, visiting about the whole body. When he came to me he had several large spots of herpes tonsurans on the anterior regions of both thighs, several spots on the legs, and several large spots on his back. The itching sensation was so very troublesome as to prevent him from sleep; he was obliged to scratch the whole night, and the skin was covered with deep excoriations caused by the nails. In this case I used at first a solution of diachylon ointment with the ichthyol, 5 per cent., to diminish the itching and heal up the excoriations. The result was very satisfactory; the itching sensation diminished and the excoriations began to be covered again with epidermis. At this point I tried to act strongly on the parasite, and I prescribed the following formula:

℞. Natr. sulpho-ichthyolic
Spirit æther, āā grms 10,00
Collodii, " 20,00

M. To be spread over the spots once a day.

With this mixture the epidermis showed an abundant desquammation, perceptible at the edges of the spots, which after a while disappeared entirely, leaving a slight pigmentation. The gentleman has entirely recovered.

I do not want to abuse your time and your patience in reporting other cases. I think ichthyol is a worthy remedy which we have recently acquired in our practice. It is of easy application, can be mixed with any other substance without trouble. Its action is mild compared with the other remedies of the same kind, and with the beneficial result produces no evil effect on the surrounding skin.

Internally it can be used in children, two to three drops twice a day, and in an adult five drops twice a day. Its disagreeable smell is easily disguised by mixing it with a little beer or a little tea. In cases of chronic catarrh of the stomach it was found beneficial. I used ichthyol internally especially in cases of eczema nervosum and of urticaria, when we need to act in the general system.

Now you will allow me to add a few words on the use of resorcin.

Resorcin has the advantage of being colorless, and the discoloration produced by its application is not so intense or so permanent as pyrogallol. Its action is displayed benefically in affections of the sebaceous glands. In cases of seborrhœa capitis it gave good results. I applied it in several cases of seborrhœa of the face, and in a stubborn case of seborrhœa nasi it was the only means which brought about a permanent recovery. A salve with 10 per cent. of resorcin spread upon a cloth and applied to the nose in the night time diminished shortly the redness. The sebaceous glands which before appeared red, swollen and inflamed, regained their natural appearance, their opening only showing a dark point from resorcin. The slight discoloration which is produced from resorcin is so mild that it does not prevent patients attending to their business.

Its reducent action is very remarkable in cases of acute eczema or eczema nervosum.

Mr. T. C. B., aged 40, a gentleman of strong and healthy constitution, has been troubled for years with attacks of eczema on the scrotum, penis and the anus. The attacks occur without any reasonable cause. At the beginning of the eczematous attack the patient experienced some uneasiness, became feverish, and at once the mentioned parts became red and swollen and on breaking discharged abundant secretion. The ordinary treatment for eczema diminished the burning sensation, healed up the resulting excoriations, the skin returned to its normal conditions, but did not prevent the relapse. I prescribed a 5 per cent. solution of resorcin in water for bathing. Since the gentleman has used this solution the eczema has not again appeared.

In cases of psoriasis resorcin was used with benefical results. It is not so strong as pyrogallol, and in recent cases of psoriasis is much better than the other. It does not stain the skin so much, is therefore better applicable to the face. Under its application the psoriatic spots take a slight brownish-yellow color, its redness diminishes, and with a slight desquammation the skin returns to its normal condition. Several cases of psoriasis treated with applications of resorcin from 2 to 10 per cent., as an ointment, disappeared in a short time.

Resorcin was also warmly recommended in the treatment of sycosis. I used it in two cases of sycosis non parasitaria, but the result was not satisfactory as I expected, and a mixture of ichthyol and unguenti diachylon showed a better result.

Resorcin in erysipelas, on account of its reducent action, resulted very beneficially.

Chrysarobin, pyrogallol, ichthyol and resorcin find their application in scars as reducing agents. But resorcin is much better applied, being odorless and staining the skin not so much as the other mentioned remedies.

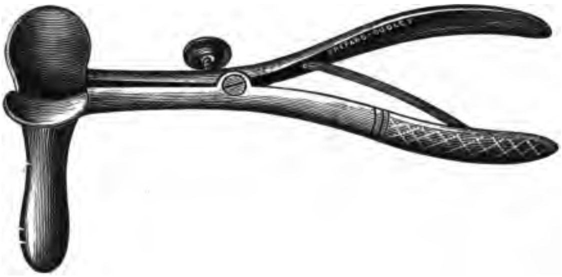
The application is usually made on the face for diminishing the ugliness of the scars resulting from small pox, acne or wounds. In this instance it is necessary to make a paste of resorcin and apply it at night over the scar. After some time the scar becomes flat and is scarcely perceptible.

Resorcin, on account of its strength, has a place between ichthyol and pyrogallol. It is easy of application, does not stain much, and its action is milder than pyrogallol. It can be applied successfully, as we have above said, in acute and in chronic dermatoses.

A NEW ANAL SPECULUM.

BY WM. R. LEONARD, M. D., New York.

Necessity being the mother of invention, we are frequently compelled to resort to various devices to obtain a more satisfactory result in operations. I devised a speculum as here illustrated, as most of those now in use are ill adapted for the object in view and of very little use in rectal examinations.



The speculum here presented consists of two blades which can be separated by means of the handles which are placed at a right angle to the blades, and held separated by a screw at the side at any desired distance. The blades are made wide to prevent the redundant folds of mucous membrane protruding between them, which frequently happens with the narrow bladed speculums. At the proximal end the blades flange out, holding the buttocks back and giving a greater field and better view of the bowel.

This speculum is especially adapted for detecting fistulæ or fissure, by applying a slight amount of dilatation and by turning the speculum slowly around in the anus; by closely inspecting the parts during this manipulation you are enabled to detect any abnormal condition that exists.

TREATMENT OF ORCHITIS.—Mr. Lowndes, in the July *Lancet*, describes his treatment for orchitis and epididymitis as it is followed in the Liverpool Lock Hospital. The patient is confined to bed and the affected testicle is painted with a 25 per cent. solution of nitrate of silver and the organ elevated on a pillow. When the patient is compelled to be on his feet, this treatment shortens the course of the disease.

EDITORIAL.

A. B. THRASHER, M.A., M.D., Editor.

PRESCRIBING DRUGGISTS AND DISPENSING PHYSICIANS.

Are druggists—and we refer especially to manufacturing druggists—finally to do all the prescribing and physicians the dispensing of medicines? From the circulars which flood the country and the advertisements which fill our medical journals, an affirmative answer to the question might seem proper. New firms are springing up in our large cities whose only business is the manufacture (?) and sale of some nostrum. These nostrums are ingeniously advertised for the purpose of getting professional indorsement.

As an example of the way our poor, innocent profession is humbugged, I quote from an advertisement received to-day:

"No advertising for the eye of the general public; personal work *solely among the profession*, giving each physician a chance to try the remedies in his own practice, thus making *him* the judge of their merits, and leaving him to prescribe them, if after trial, he thinks them worthy. We do not know of a more severe test, or one more clearly showing *our* confidence in the articles.

"In this manner we hope to keep them out of the realm of Patent Nostrums, and, in time, by their intrinsic merits, as well as by *the manner in which they are introduced*, to gain the confidence of those in whose hands we leave them."

The "personal work solely among the profession" is found to be a more efficient as well as a cheaper mode of reaching the consumer than "advertising for the eye of the general public." How generous of these public benefactors to give "each physician a chance to try the remedies in his own practice!" Of course this makes the physician merely a dispenser of medicines, and presupposes that he is unable to rationally treat his own patients. And they are very anxious that *their* medicines be not classed with "Patent Nostrums," as they depend wholly upon us physicians for support. They find it easier to dupe a few people—the ignorant doctors—than a large number of sick consumers. They depend on making the doctor act as their willing but unpaid agent in selling their worthless mixtures to the patient.

Will the physician who reads this just carefully note the insolent yet patronizing air with which these proprietary nostrums are offered him? And then we are sure he will be willing to register an oath that he will never again use or recommend any proprietary mixture.

OFFICIAL INSOLENCE REBUKED. — The following spicy correspondence is taken from a Washington special to the *Commercial-Gazette:*

PENSION OFFICE, MEDICAL DIVISION,
WASHINGTON, D.C., Oct. 21, 1886.

DR. A. Y. P. GARNETT, City.

SIR — Your certificate of sickness in the case of Miss —— is hereby returned to you as it is not sufficiently explicit. The rules of this office require that the physician shall specify the trouble with which the patient is afflicted. I have, therefore, to request that you make a new certificate and forward to this office, accompanied by this letter, as soon as practicable. The certificates of physicions are treated in this office with the strictest confidence. Very respectfully,

JOHN C. BLACK, *Commissioner,*

WASHINGTON, Oct. 22, 1886.

To the HON. JOHN C. BLACK, Commissioner of Pensions:

SIR—Your letter of the 21st inst., returning my sick certificate in the case of Miss —— received. In it you say: "The rules of this office require that physicians shall specify the trouble with which the patient is afflicted."

My first impression upon reading this extraordinary and somewhat impertinent edict was to return it without comment, but reflecting that the interests of a large number of innocent persons may be involved, I have determined to give expression to my views of the issue which you have just presented. Several years ago this question of right on the part of a Government Department to require certificates of physicians specifying the disease with which an absent employee had been affected came before the Medical Association of the District, and after a free expression of opinion by the members upon the subject, it was determined that no such demand should be complied with. It follows, therefore, that, if I felt so disposed, in refusing to furnish any such information I might base that refusal upon the verdict of the Medical Association, but this I expressly decline to do, and shall rest my action in the premises entirely upon my sense of professional propriety—the recognized obligations of physicians to their patients. In all civilized countries the relation between the medical man and his patient is regarded as a private compact, involving the personal honor of the former and possessing all the sanctity of an oath—one which no honorable member of the profession could violate without entailing upon himself personal disgrace. So sacred, indeed, is this relation that instances are not wanting where physicians have submitted to imprisonment, under the orders of a judicial tribunal, rather than disclose what they regarded as the confidences of the sick room. This question can not now be determined by the mere official dictum of a Government functionary, although clothed in the seemingly arrogant language of "requiring that the physician shall," etc. No medical man in this city who possesses a proper self respect and correctly appreciates the dignity and responsibilities of his profession, will ever demean himself so far as to comply with such a rule.

In the particular case referred to in your note, I have already informed you that the party had been and still is under surgical treatment, which physically unfitted her for the performance of her official duties. In conclusion permit me to say that as this is a general order or rule not alone confined to your office, I understand, I shall avoid the charge of being personally offensive to you when I express the opinion that the conception of such a rule must have originated with and emanated from some disciple of a school of moral ethics which I cannot condescend to recognize. It affords me profound satisfaction to add that having never accepted a fee for writing these certificates or other communications to the Government departments for its employes, I am entirely free from any possible imputation of being pecuniarily interested in the matter. Very respectfully,

A. Y. P. GARNETT.

CHANGE IN THE MIAMI MEDICAL COLLEGE. — Dr. E. W. Walker has been elected to the Chair of Surgery at the Miami Medical College, in place of Prof. Rothacker, who has resigned.

Prof. Walker is an acquisition to the already good faculty of this College. He is also surgeon to the Cincinnati Hospital.

Students of the Miami can now listen to Prof. Walker's didactic lectures at the College and clinical lectures at the Hospital.

The Miami College already has the majority of the staff of the Cincinnati Hospital, and seems to be reaching out for the rest.

BOOK REVIEWS.

BOOKS AND PAMPHLETS RECEIVED.

IS ELECTROLYSIS A FAILURE IN THE TREATMENT OF URETHRAL STRICTURES?—By Robert Newman, M.D. New York. Reprinted from *The Medical Record*, September 25, 1886.

THE BEST DOCTOR FOR THE COMMONWEALTH.—The annual inaugural address of the President of the Kentucky State Medical Society, 1886. By J. P. Thomas, M.D. Pembroke, Ky.

THE EXPLORATION, EXCAVATION, AND ILLUMINATION OF THE INTERIOR OF BONES IN ANY PART OF THE BODY.—By Milton Josiah Roberts, M.D. New York. Addressed to the Clinical Society of the New York Post Graduate Medical School and Hospital.

TRANSACTIONS OF THE OHIO STATE MEDICAL SOCIETY, 1886.—Containing as a frontispiece an admirable lithograph of the genial President, Wm. Morrow Beach, M.D.

TREATMENT OF NEOPLASMS OF THE NASO-PHARYNGEAL CAVITY.—By J. G. Carpenter, M.D. Stanford, Ky. A reprint from journal of the American Association.

NERVE-STRETCHING FOR TRAUMATIC TETANUS AND SCIATICA.—By J. G. Carpenter, M.D., Stanford, Ky. Reprint from the New York Medical Gazette.

NASO-PHARYNGEAL CATARRH.—By J. G. Carpenter, M.D. Stanford, Ky. Reprint from Gaillard's *Medical Journal*.

SEQUELS OF NASO-PHARYNGEAL AND AURAL CATARRH, illustrated by cases from private practice. By J. G. Carpenter, M.D. Stanford, Ky. Reprint from Gaillard's *Medical Journal*.

MISCELLANEOUS.

ELECTROLYSIS IN STRICTURE OF URETHRA.

Dr. Robert Newman (*New York Medical Record*, September 25th) in an article on the above subject says:

I will conclude this article with some rules, as a safe guide for practitioners who wish to adopt the treatment of electrolysis in stricture of the urethra, which will also serve as answers to numerous questions received from correspondents.

1. Any good galvanic battery will do which has small elements and is steady; the twenty-cell Drescher battery, carbon and zinc, is an excellent instrument, sufficient, particularly, for the beginner.
2. The fluid for the battery ought not to be used too strong.
3. Auxiliary instruments, as galvanometer? etc., are important to the expert, but not necessary for the beginner.
4. For the positive pole a carbon electrode is used, covered with sponge, moistened with hot water, and held firmly against the cutaneouse surface of the patient's hand, thigh, or abdomen.
5. For the absorption of the stricture the *negative* pole must be used.
6. Electrode bougies are firm sounds insulated with a hard-baked mass of rubber; the point is a metal bulb, egg-shaped, which is the acting part in contact with the stricture.
7. The curve of the bougie is short; large curves are mistakes.
8. The plates must be immersed in the fluid before the electrodes are placed on the patient, and raised again after the electrodes have been removed.
9. All operations must begin and end, while the battery is at zero, increasing and decreasing the current slowly and gradually by one cell at a time, avoiding any shock to the patient.
10. Before operating, the susceptibility of the patient to the electric current should be ascertained.
11. The problem is to absorb the stricture, not to cauterize, burn, or destroy tissues.
12. *Weak currents at long intervals.*
13. In most cases a current of six cells, or from two and a

half to five milliamperes, will do the work, but it must be regulated according to the work to be done.

14. The sceance should be at intervals, not too frequent in succession.

15. The best position for the patient to assume during the operation is that which is most comfortable for himself and the operator. I prefer the erect posture, but the recumbent or others may be used.

16. Anæsthetics I like to avoid; I want the patient conscious, so that he can tell how he feels.

17. Force should never be used; the bougie must be guided in the most gentle way; the electricity alone must be allowed to do the work.

18. During one seance two electrodes in succession should never be used.

19. All strictures are amenable to the treatment by electrolysis.

20. Pain should never be induced by the use of electrolysis; therefore it should not be applied when the urethra is in an acute, or even subacute, inflammatory condition.

JUN 20 1888

MEMBRANOUS CROUP AND DIPHTHERIA.—(Phillips, *British Medical Journal*, June 5, 1886.)

While the author believes in the etiological identity of membranous croup and diptheria, he also believes that membranous laryngitis may present two very different clinical pictures, one of which will be called croup and the other diptheria. The former will be an infectious disease of childhood, appearing suddenly at night, without any glandular inflammations, and with laryngeal breathing and false membrane in the larynx; while the other will be an infectious disease with false membrane on the throat and larynx, often with enlarged lymphatic glands, with albuminous urine and paralytic sequelæ. The experience of the author as detailed in two of his cases is interesting. In the first, a child had membranous croup with very pronounced symptoms. The dyspnea became so urgent that tracheotomy was performed with immediate relief, and with discharge by coughing of several pieces of membrane through the tube, though the child died subsequently from asthenia. A few hours after the operation had been performed, the same instruments, which the author admits had not been made perfectly aseptic, were used in performing an operation for congenital phimosis on a child eighteen months of age. Four days later false membrane appeared upon the wound of the prepuce which, by the following day, had extended over the glans, and was accompanied with much edema of the penis and retention of urine. The membrane was removed as it formed during the next two days, the underlying tissue being dressed either with iodoform or a mixture of ten grains of perchloride of mercury to the ounce of glycerine. The sequence of events here was membranous croup appearing suddenly, a course which resembled that of diphtheria, and inoculation and diphtheria of a wound after an incubative period of three and a half days.—*Archives of Pediatrics.*

POSITION IN SLEEP.—Menli-Hilty (*Der Fortschritt*) advocates a new position for the body in sleep. He says that the head should be lowered and the feet elevated. His purpose is to promote the circulation in the great nervous centre which, he claims, will cause a more rapid repair of the nervous system. He says there will be no danger from undue congestion of brain as the cerebral pressure will be properly regulated by the thyroid gland.

The author especially recommends his method of "natural sleeping" as a therapeutic agent in nervous disorders depending on cerebral anæmia, in infantile chorea, in epilepsy, in mental affections, in the first stage of pulmonary diseases; also in vesical and uterine complaints, in heart disease and as a preventative against apoplexy.

THE COMPOSITION OF "CUTICURA."—The much-advertised cuticura ointment has been found to consist of petroleum jelly, colored green, perfumed with oil of bergamot, and containing two per cent of carbolic acid.—*New York Medical Record.*

SCARLATINAL NEPHRITIS.—Dr. J. E. Atkinson, in a paper recently read before the Clinical Society of Maryland on the above subject, says in reference to the treatment great care should be taken to avoid exposure. The patient should be bathed daily and kept in bed for a week after the subsidence of the favor. With Jaccoud he adheres to a rigid milk diet in scarlatina as a preventive of nephritis; and should nephritis supervene then an exclusively milk diet is to be by all means adopted. Should cathartics be necessary he advises the use of compound jalap powder. Liebermeister arouses the skin to activity by the use of hot air or steam baths. Stimulating diuretics should be avoided. Dickinson recommends the free use of water. Leeching or cupping over the kidneys may be of service. Paracentesis should be resorted to should the ascites be excessive.

CONDIMENTS FOR THE SICK.—Dr. W. A. Hammond writes as follows: "It is rarely the case that sufficient attention is given to the use of condiments in the sick-room. They are often altogether excluded, or the patient is allowed to take them at his discretion; whereas much benefit will frequently be obtained by the judicious employment of these important agents. In certain low fevers of typhoid type, and in almost all malarial disorders, condiments may be largely used with advantage. Probably no one of them is more generally efficacious than black pepper. Mustard is also frequently relished, and we all know how grateful to us in our illness a little vinegar has been. In inflammatory affections of the stomach and bowels, the stronger condiments, such as pepper, cayenne, mustard and horse-radish are seldom admissible; but many cases of diarrhœa are very decidedly benefited, especially when they occur in persons who have somewhat run down in general health, by black pepper, cayenne or mustard, taken in quantities far above those which a healthy person would be likely to ingest. I have frequently known severe cases of diarrhœa to be cut short by a few doses of twenty or thirty grains each of cayenne, taken either in a little water or syrup. Black pepper is well known to be a remedy of no mean power in the common fever and ague of this country. It will often cut short attacks with as much promptness as would large doses of quinine."—*Journal of Reconstructives.*

LARGE VESICAL CALCULUS.— In the the *Lancet* Mr. Thomas Smith reports a case of suprapubic lithotomy. The patient was a soldier, aged 43, and sought medical advice on account of frequent micturition. The stone had an oxalate neuclus, coated with phosphates. It weighted 24½ ounces and measured 13 inches in its largest and 9½ inches in its smallest circumference. The patient made a good recovery.

THE

CINCINNATI

Medical and Dental

JOURNAL.

Vol. II. Cincinnati, November, 1886. No. 2.

DENTAL DEPARTMENT.

DR. HERBST'S OBTUNDENT.

With Various Opinions Thereupon by Members of the American Dental Association.

Dr. Bodecker said he would be very glad to tell them what he knew about the obtunder. Dr. Herbst had given it to him and told him of its effects two years ago, but he had felt he ought to be a little careful about it before daring to bring it out. He had in the mean time tested it and found it perfectly safe. It was simply a little chemically pure sulphuric acid, saturated with hydrochlorate of cocaine, stirred with a glass rod until perfectly dissolved (which would also give a test for the purity of the cocaine—if the solution changed color, turning dark, there were impurities, as carbonaceous particles, etc., in the cocaine). When the sulphuric acid will dissolve no more cocaine, add sulphuric ether until super-saturated, still stirring with a glass rod. It must not be shaken in a bottle as the expansion is liable to break it or force the cork out, throwing the acid in the eyes. It is safest prepared in a long test tube stirred with a glass rod. If any ether remains on top it will evaporate by standing. A little is to be taken upon cotton and applied to sensitive dentine. The effect is more beautiful than anything else ever tried. It only obtunds one layer, and then another application must be made. Its action is very nice and very prompt. It is not necessary to weigh or measure either the cocaine or the sulphuric acid. It will not take up any more than enough. The cocaine obtunds the momentary pain caused by the application of the acid.

Prof. Taft said it had been his privilege to be three days with Dr. Herbst. With regard to this obtunder, he would say it struck him as very peculiar when the formula was first given. For his own satisfaction he had weighed and measured, and found that one drachm of sulphuric acid would dissolve thirty grains crystals of cocaine. The amount of sulphuric acid was not important. as any over saturation would evaporate. He had used it daily for three months and in every instance it had been sneccessful. Its action was very simple as far as the process was concerned; the sulphuric acid dissolves a layer of dentine, acting as a caustic on the living tissues; the cocaine obtunds the pain of its action, the ether serving the same purpose. It should be applied after drying the cavity and before excavating. If the cavity is well formed there will be no objection to leaving in the bottom the powder which will be formed by the dissolved dentine, which is sulphate of lime. The acid is satisfied with what it has dissolved and its action cannot go beyond that point.

Dr. Jos. Truman feared that the obtundent mentioned would be productive of great injury. The dentine contained a prolongation of the pulp tissue, which is destroyed to that extent, and the irritation must eventually extend to the main body; this was the result of any escharotic applied to a sensitive surface. He was surprised to hear Dr. Taft endorse a preparation which he admitted would cause crumbling and disintegration. He felt that he must utter a word of warning against the indiscriminate use of such an agent,—which would result in the destruction of pulp tissue.

Dr. Taft said that in endorsing the obtunder he spoke only of his own experience with it. He would also state that Herbst had used it for five years with the best results, so far no unfavorable results having been detected. The reasoning of Prof. Truman can hardly be borne out; its action was not so violent as his language would lead us to believe. Sulphuric acid had been used for years in alveolar abscess and in various surgical operations; if its action was so violent it would be totally impracticable for the purposes named. It is an escharotic but it destroys only the surface; there its action ceases, it reaches only one layer and is not an agent capable of doing the mischief ascribed to it by Dr. Truman. My only fear is that some will refuse to use an agent which would be of great service.

Dr. Rehwinkel said that *veretria* was of great value as an obtunder, as follows: half grain of veratria to three drops of absolute alcohol, to which is added tannin to saturation; then add ten drops of glycerine. Apply after the dam is in place and the tooth dry. It is, however, exceedingly poisonous.

Prof. Truman said he would only reply that an escharotic could not be placed in contact with dentine without disturbing the main body of the pulp. Dr. Herbst had a very different character of tooth structure to deal with—teeth of very dense character, while here teeth were of soft structure and such agents could not be used with safety.

Dr. Bödecker said he must correct that inference. Dr. Herbst had shown him teeth of very poor structure (children of ten and twelve years of age, for whom he would under no circumstances have used gold) which had been treated with this escharotic. They were found in perfect condition, the edges absolutely perfect, resisting every test. In one case the pulp had been exposed but had survived, as was proved by the ice water test. He hoped next year to show the effects in four of his own teeth in which the obtunder had been used.

Dr. Morgan says there is no risk in using an agent when we know its limits. If we know it to be self-limiting it is perfectly safe.

Dr. Brophy said he had seen pulps devitalized by obtundents. We want to be very careful what we use, but only experiment will demonstrate what it will do.

Dr. Sitherwood said that as he understood it, the principal agent, sulphuric acid, was known to be self-limiting, and therefore would do no harm.

Dr. Taft repeated the formula and explained again the formation of sulphate of lime in the cavity, an insoluble powder, beyond which the acid cannot act. It is satisfied with what it has dissolved.

Dr. Atkinson said that was where it differed from chloride of zinc, or arsenic. You never know when their action will cease; it may go on for months. Chloride of zinc acts as an obtundent by changing the pulp into hypochloride of albumen, as clear as glass, to the apex. He wished to speak to defend the man who cannot speak English.—[*From the Ohio State Journal's Report.*

OLD AND NEW REMEDIES.

BY A. J. SEIFFERT, POTSDAM.

[Translated from the Deutsche Monatschrift für Zalmeilkunde.]

It is astonishing how much the human mind likes something new, and how quickly men part from something good, but old, as soon as a new thing is offered to him, which is pretendedly better. That is especially the case with the many remedies, which are recommended in the course of time for toothache, for pain in spaces from which teeth have been removed, painless extraction of the teeth, etc. A man has to smile, when, as soon as a new remedy is recommended, the credulous fall upon it eagerly, to try it, and to communicate with their colleagues about the dubious results of the application. Only a few take their time, to continue the investigation long enough, for enabling them to pass judgment with certainty. This has relation for example to iodoform, and recently to cocaine.

In regard to the application of new remedies two questions have to be taken into primary consideration. Is not the remedy disagreeable to the patient by its smell and taste? and, Have we not older remedies, which answer the same purpose as well, and in certain instances, possibly better, than the new ones? Let us pass review on these questions in reference to iodoform and cocaine.

Regarding iodoform, all people agree that the saffron-like smell of it is highly disgusting, although, under circumstances, good results were obtained with this remedy. To remove this smell the most heterogenous corrigants have been used, as cloves, osmarin, and a druggist even imagined to give a mild aromatic smell to the preparation by adding a small quantity of oil of sassafras. Whether it is the fault of the oil, or dependent upon a peculiarity of my nose, there is no doubt, with these additions the remedy is mueh more disgusting to me, and the horrible smell sticks to the fingers for hours, although they are washed carefully.

* * * * *

The question may be asked, if it cannot be replaced in dentistry by other remedies which do not smell so strong, even if they are a little less potent, and this question must decidedly be answered in the affirmative.

A long while before iodoform was recommended the writer of this article used decolorized tincture of iodine with the best success, moistening little pads of wadding with the tincture in the primary stages of inflammations, and putting them into the inflamed tooth; he recommended also to the patient to rub with the same tincture of iodine that place of the arch of the alveolus, which revealed the position of the inflamed root, by being painful to pressure. Incipient inflammations will always be scattered in this way, but it should not be forgotten to recommend at the same time to take one and a half glasses of the purgative Hungarian mineral water (every other day, in the morning) as a derivative. Not seldom the patient will complain of pains in the region of the temple and the forehead, but also here it is sufficient to rub the aching place with the same composition, to which is added some chloroform, and then to rub with it toward the aching tooth in the direction of the nerve. In pains in the forehead, it is a matter of course, only a few drops should be on the wadding to prevent the mixture from irritating the eye. A remedy of such efficacy as iodoform may nevertheless aid the surgeon as well as the dentist in their efforts if it is used externally; indeed, it might even be asserted, there is no better remedy for scattering humors than a plaster of iodoform.

In the treatment of more or less obstinate tumors, as the case may be, iodoform should be applied in combination with sticking or lead plaster in the proportion of 1–4 or 1–8 or 1–12, for example:

Rp.	Iodoformic pulv.	2,0
	tere extracte c. Coumar.	0,5
et adde	Ephlas tr. plum C.	
	" adhæsiv.	$\widehat{aa}$ 4.0
	M. J. empl. S. Empl. Iodoform. fors.	

Sometimes it happens that after inflammation of the root smaller or larger swellings of the parotid or submaxillary glands will remain. In such cases the iodoform plaster removes them surely and quickly, for in most cases the application of the plaster for one night only is sufficient to effect the scattering.

Physicians frequently order the application of the tincture of iodine by rubbing when they meet with considerable swelling of the glands. In this case the covering with strong iodoform plaster has a quicker effect, the remedy can work better under the warm cover; besides this skin will not be colored brownish-yellow, neither will it be destroyed, as it is regularly the case when tincture of iodine is applied, Serious avoidants, which indicate poisoning, have sometimes been observed with the internal application of iodoform; the best mode of counteracting them is the use of bicarbonate of potassium.

Nearly all that has been said of the iodoform applies to cocaine. If the former remedy is looked upon as having a dangerous effect upon the health this is the case in still a higher degree with the last named. The experiments instituted by Montegazza and Niemann have proved this. Niemann thinks this remedy is not to be trifled with, that it is even extremely dangerous. The more the dentist has to restrict himself to use it only in extreme cases, and to give up every sort of experiment with it, as he cannot foresee what the ultimate result may be. If such pains are to be investigated by it, which appear during filling the teeth, we have in place of it another older remedy that answers the same purpose without ever giving any cause for anxiety. It is the well known morphine-phenoltannin preparation of Witzel. One drop of it is to be put into the aching tooth every two or three minutes, and one can depend upon that the pains will be completely removed at the third, seldom at the fourth time.

Certainly the remedy has the disadvantage that a brownish coloration of the previously excavated dentine is produced, but even this may easily be removed by syringing with water.

Besides this, it has also been claimed for the cocaine that it will stop such pains as are caused by the extraction of inflamed roots or teeth. Just as speedy effects, as with cocaine, may be obtained by filling the cavity with little pads of wadding dipped in tincture gelsemini. Usually it is only the violent pain which remains that has developed in the course of the nerve or in the ganglion from which the nerve originates; the remedy to remove this pain (tinct. iodi. decolorata with chloroform) has been previously mentioned.

Cocaine heightens the ability of the body in performing its duty in marching, ascending mountains, etc. The dentist, however, has little cause for using the expensive remedy for his purposes, but there are rare cases where he might use it: while taking impressions, if the patient suffer from nausea; and if the case requires bringing the plastic mass very far into the back part of the mouth, as it has to be done, for instance, in covering up defeets of the palate by apparatus. In this case is would be a good plan to use a mixture of cocaine, morphine and glycerine to rub the palate with. If, to remove pains in extracting teeth, a subcutaneous injection of the remedy on both sides of the tooth is recommended, the dentist would do best in refraining from the use of such heroic remedies, as on one side he seldom will thereby succeed in gaining the intended purpose, and on the other side even the danger of the subcutaneous injections with cocaine was manifested.

To cite an example what great mischief the desire of innovation may do, even in medicine, we only need to cast a look upon the subcutaneous injections of morphine recommended by the physicians. In consequence of them a disease of its own kind, the morphine mania, has developed, which is spreading farther and farther, and causing the greatest mischief in very many families. The cause of this is that many physicians prefer to place the Parevaz syringe into the hands of the patients instead of performing the operation themselves. That should never happen, as the patient when he once has known the sweet intoxication which is produced by an injection of morphine or by the use of morphine in general does not know either moderation or limit, and does not care the least whether by such a treatment his body will suffer lasting damage or not.

Those physicians who now oppose the subcutaneous use of morphine have noticed another injury, although less observable, which is caused by these injections. In the surroundings of the injected place the cellular tissue thickens, and the sebaceous, as well as the sudorific glands in the vicinity, will hereby be prohibited from performing their office. As, however, some morphine-maniacs make three, four, to five injections daily, it is a matter of course that gradually a large number of these important glands will refuse functionating, and perish.

But, to come back to the main point, after this digression, the nervosity of mankind is increasing more and more, as is admitted; but instead of reducing the same, and searching for remedies which remove the causes, paliatives are used which apparently suppress, in fact, however, continually foster them. Thus the question may be started: "Which evils will be produced by the apparently indiscriminate use of cocaine?"

In more recent time one of the older, well-tried remedies has again proven of great value in dentistry, as it has been found that in efficacy it surpasses by far all other so-called *antiseptics.* It is the "Corrosive Sublimate." The divers preparations of it have to be subjected to a stricter and more extensive investigation. The writer of this article would call the attention to the fact that, besides this remedy and calomel, the two corresponding medicaments, "Red Iodide of Mercury" and "Yellow Iodide of Mercury" may be tried. It was in vain that occasion has been taken to replace calomel in the treatment of typhoid fever by other medicines. *There is no remedy which destroys with such speed the spicothætasop of the stomach and bowels, and frees the blood from those micro-organisms, as calomel.*

The red iodide of mercury (hydrarg. iod. rubr.) may be compared with the corrosive sublimate; the yellow (hydrarg. iod. flav.) with the calomel. But the red is said to be possessed of far greater causticity than thc corrosive sublimate, and, consequently, should be used only with the greatest caution. Both remedies are soluble in ether. Hydrarg. iod. flav. was many years ago a favorite remedy of the authoı for the parasites of syphilis, by the use of which he succeeded in curing the most severe and inveterate form of that disease. It presents only this one fault: that by the rays of the sun it is reduced and becomes grayish-black, while hydrarg. iod. rubr. is not changed whatever.—*Office and Laboratory.*

◆

IF NOT, THEN WHAT?

By L. P. HASKELL, Chicago.

The discussion still goes on in regard to the effect of rubber plates on the mucous membrane, not only of the mouth, but of the throat, stomach, and sometimes of the entire alimentary canal. There is a determination on the part of some to deny that there are any injurious effects whatever, except as they claim, are incidental to the use of any materials for plates in the mouth.

One rises, in a convention, and with his thumbs thrust in his vest pocket, and with an oracular air, announces that the peculiar conditions existing under rubber plates are owing to the plates not being smooth, and not being kept clean. Another asserts that if the mouth is cleansed with a tooth brush there will be no trouble; and still another says if the plate is left out nights the bad effects will cease. For forty years I have been engaged in this specialty, and for the last fifteen years have paid particular attention to the conditions of the mouths, noting especially the difference under various materials. Eight years ago I spent two months in Boston, where I had formerly practiced. I had occasion to meet many of my old patients, who were wearing full sets, made 22 to 28 years previous. Of course, they were all metal, having been made before the advent of rubber. In every case the gums were hard and healthy, showing no signs of absorption since the plates were inserted. This was quite a revelation to me, as I had been accustomed for several years to witnessing the ravages of rubber plates, many cases where the process was all gone, and in the vast majority of instances where these plates had been worn for five years and upward, showing undue and constant loss of process.

As to the lack of smooth surface, I have seen just as bad results under a glassy surface as under a surface not as smooth; and as to lack of cleanliness, have seen many metal plates, just as filthy, and yet no such conditions of the membrane. No, gentlemen, these results are the effects of a *non-conducting* material,—just how it acts I cannot say. Independent of this there are other effects, that occur *only* under the red rubber. If it is not the mercury, then what is it?

I will cite a number of cases, Dr. Justin Hayes, of Chicago, a well known physician, had a partial set on red rubber plate. In less than an hour after its insertion, he was seized with spasms in the throat, which were relieved only by the removal of the plate, and recurring again on its insertion; after a thorough trial he gave it up and had one of black rubber made precisely like the other, which he has worn many years, with no inconvenience.

Dr. H. had sent me a patient who had worn a full set of red rubber for seven years, and during the entire time had a singular condition of the stomach. Even with a fair appetite he would recoil from the presence of all food except in a liquid form. His whole nervous system was unstrung. Dr. Hayes in diagnosing found these red rubber plates, and told him to have them replaced with metal. He came to me and on consultation told me he could not afford metal, so, as an experiment, I made him celluloid plates, which has the same coloring material. He left feeling quite happy. In two weeks he returned, saying he was as bad off as before, after wearing them a week, and by the advice of a dentist, had left them out for a week, and was much better. I then made him metal plates, and he has had no recurrence of the trouble, now six years. A lady who had worn a red rubber plate for twelve years, and during the entire time had a sore mouth, stomach trouble, and chronic diarrhea, was at once completely relieved by the substitution of metal. Her physician afterward told her he had treated her for symptoms of *mercurial poisoning*, but whence it originated, and why he could not mitigate the symptoms, he could not see. The symptoms would return in twenty-four hours on replacing the rubber plate.

Another lady had worn red rubber plates for two years, and during the entire time suffered from chronic diarrhea, having at times twenty operations of the bowels in twenty-four hours. The substitution of metal plates at once relieved her. The wearing of the rubber plate for a day would produce the old symptoms. Her mother was a homepathic physician, and wondered why none of the usual remedies failed to produce any relief.

Another lady, who had worn a red rubber plate for five years had constantly a sore mouth, extending around the outside at the corners, inflamed throat, and stomach trouble; her throat finally became so inflamed and partially paralyzed that she could not swallow solid matter. After consulting dentists and physicians, a young man, a recent graduate from a dental college, told her the trouble was caused by her rubber plate, and to demonstrate it, told her to leave it out for a week. She did so, and immediately began to improve. The dentist after a while made her a set on metal, and she had no recurrence of the trouble till several months after. Her children bantered her about chewing gun, telling her she could not, on account of her false teeth. To show them she could, she chewed some for two days, and her old symptoms returned. On investigation it was found the gum was what is known as "rubber gum" and made of red rubber.

If these facts can be explained on any other hypotheses, than *mercurial poisoning*, I am ready to be convinced.*—*Items of Interest.*

---

*Let us have a full expression of our brethren on the other side.

MISCELLANY.

A STARTLING SURGICAL OPERATION.—On account of the many inconveniences attendant on the wearing of an artificial eye, five attempts have been made within the last year to replace the lost organ by the living eye of an animal which it was thought might be made to grow in its place. One dog and four rabbits have contributed to these experiments, one of which came so near being a success that the operation of transplanting an eye is no longer an improbable attainment. Dr. Bradford, of Boston, Mass., the third surgeon who, as far as is known, has attempted the operation, and the only one who has met with anything like success, was able to report, after three weeks' time, that what was supposed to be the critical period had passed; that the eye was in place, and though somewhat dull and disagreeable to look at, was improving in appearance daily. Since then a number of successful cases have been performed on the lower animals. Sooner or later we surgeons may come to rival About in the brilliancy of our conceptions, though our knives have hardly the daring of that able Frenchman's pen.—*Harper's Bazar.*

[We hardly know what to think of this. It looks a little suspicious. The season of campaign lies is upon us. We will wait and see if that dentist somewhere on the Pacific Coast, who has started a garden plat of human teeth on a rooster's comb, takes any notice of the above extract. It looks to us like a heavy cross-counter on his jaw. Let us see if he gets his "second wind."—ED.]

TO OBTAIN ADHESION FOR ARTIFICIAL-TEETH PLATES.—An exchange states that this may be accomplished by sprinkling over the surface of the plate powdered gum Tragacanth. The powdered gum is put in a bottle, over the mouth of which is tied a piece of muslin or tarletan. Many plates, though made on the model, from a perfect impression, fail at first to adhere either from the inability of the patient to create an exhaustion or from some other cause. The above is given by several dentists who have used it successfully, some going so far as to say that considerable force will, at times, have to be used to remove the plate when this is used. The suggestion is simple and worth the trial.

BIBLIOGRAPHY.

A Practical Treatise on Mechanical Denistry. By Joseph Richardson, M.D., D.D.S. Fourth edition, with four hundred and fifty-eight illustrations. Philadelphia: P. Blakiston, Son & Co., No. 1012 Walnut street. Cincinnati: Robert Clarke & Co. 1886.

This volume, a very complete exposition of mechanical and prosthetic dentistry, contains seven hundred and two pages of reading matter, an increase of two hundred and sixty-four pages over the the third edition. In the third edition fifty-five pages were devoted to the so-called operation of "pivoting" roots. The fourth edition devotes one hundred and ninety-three pages to this subject and "bridge-work." Several chapters have been re-written or added to, in order to meet the requirements of the latest improved ideas and requirements. This edition seems to include all that is new and valuable in the mechanical branch of dental art. In cloth, $4.00; in leather, $4.75.

◆

The Platina Surrounding Clasp. — For every one-sided plates we run a round platina wire round a molar on the opposite side of the mouth, where space will permit, instead of the bungling rubber, which too often irritates the cheek; this being made into the plate either by soldering covered ends with gold, or bending at right angles, placing a dot of thin vulcanite at the point which would touch on the cast, wax over and pour the upper section of flask, and when you pack, the two portions of rubber will come together holding everything to its proper place. The wire may be safely stretched a little on your anvil if too tight to go over the natural tooth. It is taken for granted that you have obtained a perfect model to work on by the usual process of wax and plaster, both. By one-sided plates we mean where, for instance, the the teeth commence at the central and so running back.—*Mansfold's Band of Hope.*

"Pearline," a laundry powder sold by all grocers, is an excellent preparation for removing stains from the hands and finger nails. Try it after handling flasks and laboratory tools.

THE

CINCINNATI

Medical and Dental

JOURNAL.

Vol. II. Cincinnati, December, 1886. No. 3.

MEDICAL DEPARTMENT.

A CASE OF STRYCHNINE POISONING SUCCESSFULLY TREATED WITH LARGE DOSES OF BROMIDE OF POTASSIUM AND CHLORAL.

By JOHN L. DAVIS, A.B., M.D.,

Lecturer on Materia Medica and Therapeutics, and Physician to the
General Medical Clinic, Medical Department of the
University of Southern California.

At 9 o'clock in the evening of August 23, 1886, I was hastily summoned to see a man who was suffering from agonizing muscular spasms.

The man was thirty years of age, well developed and fairly nourished, and when first seen by me was suffering intensely with constantly recurring cramps in the muscles of the abdomen, back, arms and legs. The pulse rate was 90, full and regular; the respirations were deep, and numbered 16 per minute; the face was flushed; the eyes prominent and staring, pupils normal. The whole body was freely bathed in perspiration. The patient was conscious and rational, answering questions naturally, though groaning with pain.

Upon questioning the patient and his family, it was ascertained that he had for some weeks, by his physician's order, been taking strychnine as a tonic. On the morning of the day in question, the 23rd, he bought thirty-five cents' worth of strychnine — about a teaspoonful, he said. (I subsequently ascertained from the druggist who sold it, that the exact quantity was twenty-seven (27) grains.

The man was much worried and excited over certain business matters, and thinking the drug would act as a stimulant, he took indefinite pinches of the strychnine powder repeatedly during the morning, and before noon had swallowed the whole amount.

Being busy, he neglected to get his dinner, and early in the afternoon he became dizzy and fainted twice; after this—perhaps two hours—he vomited freely three or four times, and late in the afternoon, very greatly prostrated, he was sent home in a carriage.

He was put to bed, and members of the family, at first suspecting that he had taken some indigestible food, gave him twice large doses of bicarbonate of soda to excite emesis. This, however, was ineffectual, and he was afterwards given black coffee as a stimulant. He began to complain of a burning pain in the stomach, and soon the family noticed the onset of abdominal cramps, and pain commenced in the arms and legs and to a less degree in the back.

The family, now for the first time becoming alarmed, sent for me. When I first saw the man the muscular cramps were recurring about every two minutes. The paroxysm would begin in the abdomen, the maximum of intensity being reached there in from five to ten seconds, and the agony 'bending the patient double,' and causing him to grind his teeth, which action was accompanied by spasm of the jaw, and followed immediately by violent contraction in the muscles of the arms and legs, particularly in the calves; and the paroxysm was ended by the spasm in the back, which would bow the body forward and cause the patient to roll on his side—otherwise he would have rested solely upon his head and heels, as the tension of the muscles was extreme.

The duration of the paroxysm was about thirty seconds; and the patient's suffering during the time was intense. In the intervals he was quiet, and comparatively free from pain, though exhausted.

Upon learning the history of the case, I deemed an emetic useless and immediately gave from my pocket case forty grains of chloral and ninety grains of bromide of potassium. At the same time I had a mustard plaster applied to the abdomen, with the hope of ameliorating the pain there. In a few minutes free emesis occurred, the matter vomited being about twelve ounces of watery fluid, containing half a dozen pieces of peach which the patient did not remember to have eaten. I then administered thirty grains of chloral and one hundred grains of the bromide. The spasms in the mean time had become more violent and alarming and they continued to grow still more violent until their intensity was reached, about ten minutes after the administration of the second dose of medicine. From that time they diminished in severity; the paroxysms becoming less and less frequent, and their duration shorter. Half an hour after the second dose was given, there began to be a recurrence of the spasms, and I administered one hundred grains of the bromide. This was about one hour after I had given the first dose, which was vomited.

From this time on the paroxysms diminished in frequency and intensity, and at eleven o'clock I thought the patient could be left for the night; I ordered ten grains of bromide of potassium to be given every hour while he was restless or wakeful; and in case the spasms recurred, I was to be called. There was, however, no recurrence of the muscular contractions, and when I saw the man the next morning at seven o'clock he was suffering only from a headache and severe soreness all over his body, painful upon touch and movement.

The subsequent treatment consisted of a simple astringent for a diarrhœa that occurred, and a tonic afterwards. Recovery was complete.

COMMENTS.

This case is remarkable chiefly in the fact that so long a time intervened between the ingestion of the poison and the appearance of toxic phenomena. The drug was taken in frequently repeated doses extending over a period of four or five hours; after this, at least two hours elapsed before the man fainted; and it was only subsequent to this fainting that vomiting occurred. Hence the whole amount of the poison must have remained in the stomach for over two hours; or, a minute portion of it may have been digested and distributed through the system. After free vomiting, several hours more passed — at least three or four — before the muscular convulsions were manifested. The bicarbonate of soda may in some measure have decomposed the poison, but it was only given shortly before the spasms began.

The most rational explanation of the delay in the appearance of toxic symptoms, is that gastric digestion was completely, or almost completely, checked by the influence of the mental excitement and anxiety to which allusion has been made. It is well known that under conditions of great mental disturbance the digestive functions may be suspended for hours; and this case, I think, strikingly illustrates this fact.

The quantity of strychnine taken was twenty-seven grains in the form of powder, and ordinarily this would have been digested by the gastric juice within a few minutes — certainly within fifteen or twenty minutes; for strychnine is one of the rapid poisons. and its toxic effects are usually manifested in less than ten minutes. It is true that the daily use of the drug continuously for several weeks may have produced a tolerance which rendered the patient less susceptible to its effects. Nevertheless, however great this tolerance may have been, it could not have rendered twenty-seven grains inert if they were once fairly in the circulation. Hence we must conclude that the poison lay in the stomach under conditions which prevented its absorption—except possibly in the minutest quantity.

The fainting may have been due to the man's failure to eat dinner at the usual time; slighter causes than this have produced fainting.

Finally, the stomach became stimulated by the poisonous irritant, and free vomiting followed. A small quantity of the strychnine however, entered the circulation at length, and as a result the muscular spasms were manifested.

The large doses of chloral and the bromide of potassium acted admirably in controlling the muscular cramps fully and speedily; and small doses of the bromide exhibited frequently throughout the night prevented any recurrence of the cramps after they were once controlled.

* * *

Since the notes were taken from which the foregoing description is written, two more cases of strychnine poisoning have occurred here. Both men took the poison with suicidal intent, and in both cases the result was fatal. In one instance half a drachm, and in the other one-fourth of a drachm of strychnine was taken.

Los Angeles, Cal.

INFLAMMATION OF THE EXTERNAL EAR TUBE.

By FRANCIS DOWLING, M.D., Cincinnati,
Late of Prof. Galezowski's Ophthalmic Clinique, Paris.

CASE.—Mr. N. came to me on the 9th of last August to consult me about a trouble of his left ear. He gave the following history of his case:

About two weeks previous to this time he consulted a physician about some difficulty of hearing. The doctor told him it was caused by wax in his ear, and gave him some application to dissolve it. After about a week's treatment he consulted another physician who injected some liquid into his ear; soon afterwards he felt as if some one had a put red-hot coal into his ear. He now consulted his family physician who very properly dropped a solution of cocoaine into his ear, to allay the intense pain, from which he was suffering. He came under my observation about the third day from this time. I found him suffering with violent pain in the region of the back of the ear and temple; could not sleep. Mastication caused intense pain, and consequently the patient could take nothing but liquid food.

I found the external auditory canal so much swollen that it was impossible to introduce an ear speculum, and consequently could not get a view of the tympanic membrane; pressure beneath the ear caused intense pain, which made the patient feel like fainting. I ordered warm poultices to be applied to the ear and side of the face, covering the area of the tenderness. Also the following to be dropped into the ear three times a day:

℞	Morph. sulph.	grs ii.
	Glycerine	℥ii.

About the end of the third day the acute symptoms had subsided and the swelling of the external meatus had sufficiently given way to enable me to inspect the membrana tympani. There seemed to be a uniform opaqueness of the membrane, with a bulging outwards toward the center. The summit of this bulging was covered with red lines, evidently congested blood vessels. There was a sero-purulent discharge from the ear. I insufflated a powder composed of morph. sulph. and bismuth. subnit. into the ear once a day and ordered the patient to keep the canal cleansed by injections of warm water. This treatment I continued for about two weeks when the patient was discharged, cured.

The above case was evidently acute myringitis with diffuse inflammation of the external meatus, and there is no doubt but what the strong injection was the cause of the affection.

While acute inflammation of the ear drum may be caused by cold currents of air, sea bathing, cold baths, etc., acute diffuse inflammation of the external ear tube, on the other hand is rarely met with except as a consequence of mechanical irritation, the injection of irritant substances into the ear and traumatic causes. The disease as an idiopathic affection is extremely rare, in fact, Bezold says that the disease as such has no right to a place in the pathology of the ear.

Acute inflammation of the external ear canal, under appropriate treatment, usually terminates in recovery, except in cases where the membrana tympani is seriously involved in the inflammation. Then deafness may remain for some time after the inflammation of the meatus has subsided. In the case mentioned above the hearing remained so much impaired, even after the acute symptoms had subsided, that the watch tick, (Waltham), could be heard at no greater distance than two inches from the ear. The condition has since materially improved and there are indications that the case may finally terminate in complete restoration of the function of hearing.

The disease sometimes terminates in ulceration of the membrana tympani with perforation from without inwards, and it would be well to state in this connection that injections of solutions of arg. nit. zinc and other astringents ought to be carefully avoided in cases of this nature, as part of the injected liquid is apt to be forced into the cavity of the middle ear through the perforation in the membrana tympani.

The contracted meatus usually returns to its normal caliber after the subsidence of the inflammation, but occasionally more or less stricture of the canal remains. In such cases the parts may be dilated at first by means of conical pads of cotton wool smeared over with ungt. diachylon (Hebra). If this means does not succeed after a fair trial, compressed sponge tents may be introduced, gradually increasing their size as the progress of the dilatation continues, but in this connection it will be well to mention that as soon as the swelling of the tent produces any amount of pain, it is to be immediately removed. It can be re-introduced the next day, and so on until the requsite amount of dilitation is accomplished. In old cases of contraction, caused by hypertrophy of the lining membrane of the meatus, this treatment will do very little good, as the contraction returns as soon as the dilating process is discontinued. In such cases Prof. Politzer, of Vienna, recommends repeated longitudinal scarifications of the cartilaginous meatus, with subsequent introductions of the compressed sponge tents.

This procedure often affects a cure of the contraction after all other remedies have failed.

DIET IN PHTHISIS.—The following may serve as a sample menu for a day in the earlier stage. The meat soup is made by digesting finely chopped beef (1 lb) in water (Oj) and hydrochloric acid (5m) and straining through cheese cloth.

MENU.

On waking.—One-half pint equal parts hot milk and vichy, taken at intervals through half an hour.

8 a.m.—Oat meal with abundance of cream, little sugar; rare steak or loin chops with fat, cream potatoes; soft boiled eggs, cream toast; small cup of coffe, two glasses of milk.

9 a.m.—Half ounce cod liver oil, or one ounce peptonised cod liver oil and milk.

10 a.m.—Half pint raw meat soup; thin slice stale bread.

11–12.—Sleep.

12.30 p. m.—Some white fish; very little rice; boiled or stewed chicken; cauliflower; stale bread and plenty of butter; baked apples and cream; milk, Kumyss or Matzoon, two glasses.

2 p.m.—Half ounce cod liver oil, or one ounce peptonised cod liver oil and milk.

4 p.m.—Bottle Kumyss or Matzoon; raw scraped beef sandwich.

5.30–6 p.m.—Rest or sleep.

6 p.m.—Some thick meat or fish soup; rare roasted beef or mutton; spinach; slice stale bread; custard pudding; ice cream.

8 p.m.—Half ounce cod liver oil, or one ounce peptonised cod liver oil and milk.

9–10 p. m.—Pint iced milk; cup meat soup.

1–2 a.m.—Glass milk, if awake.—Prof. Loomis, *Journal of Reconstructives*.

ON CHRONIC SUPPURATION OF THE MIDDLE EAR.

By C. W. TANGEMAN, M.D.,
Assistant to Chair of Ophthalmology at the Ohio Medical College.

Chronic suppuration of the middle ear has, until recently, been regarded very lightly by the profession generally. This affection is called by the laity "a running."

The diagnosis of this disease, so frequent among children, and so often one of the sequelæ of acute affectious diseases, is not at all difficult; many times the patient makes his own diagnosis.

The most prominent symptom is the discharge of pus through the auditory meatus from the middle ear. With few exceptions, we can say that a discharge of pus from the meatus comes from the middle ear through a perforation in the membrana tympani. The discharge is often quite profuse and possesses such an offensive odor as to cause these unfortunate patients to be shunned by their playmates or fellow associates.

The hearing power is often very much impaired, not so much, possibly, on account of a perforation that exists in the membrana tympani, as on account of the changes produced in the middle ear by the ulcerative process.

The discharge may be so acrid as to cause an erosion of the integument of the meatus auricle and side of the face.

When the process has become chronic it is not often that the patient complains of pain. It is this latter fact, with the advice that the older physician was and is in the habit of giving, "never stop a discharge from the ear, or it will break out some other place," that leads individuals to quietly submit to the fate of losing their hearing, and, in many instances, their lives.

The membrana tympani presents a varied appearance; in one instance, the perforation may be large, the patient being able to force air through it; in another, it may be small, or there may be two or three small openings. Cases are not rare where the entire chain of bones has been swept away by the ulcerative process.

The causes of this disease are many; but in most instances the disease is caused by an extension of an inflammatory process through the Eustachian tube to the middle ear.

Hot water, applied to the ear every half hour by letting it drop into the meatus when the patient complains of earache, would possibly prevent many a case of acute suppuration, or if it would not prevent it, the process might not become so destructive.

The result of these cases going untreated is only, in too many instances, a bad one, many patients dying under the observation of a physician who never even suspicions that disease of the ear, and of the ear alone, is the cause of death. Life insurance companies decline to accept risks on subjects afflicted with chronic suppuration of the middle ear. The disease becomes so dangerous on account of the close proximity of vital parts.

The anatomical character of this disease is well enough understood to explain why the disease in many cases is so intractable to treatment.

The diagnosis is not difficult, and can be made by the merest tyro in medicine, even without a reflector and ear speculum, though these instruments are indispensable to any one attempting to treat diseases of the ear.

What interests us most, as practitioners of medicine, in connection with this disease is the prognosis and treatment.

Prognosis, so far as life is concerned, is good, if the case is properly treated; the arrest of the discharge of pus can always be accomplished, but in the large majority of cases the normal acuteness of hearing is never restored. This may be due to a pathological condition of the Eustachian tubes, an altered or thickened condition of the mucus lining covering the middle ear, or a destruction of the entire chain of bones and membrana tympani by the ulcerative process.

On account of the relative frequency of this disease in childhood and the importance of a cure, our interest is mainly centered in the treatment.

The course of the disease, as pointed out above, is often quite destructive, and the efforts of treatment must be directed toward checking its progress and restoring the diseased structures to their normal condition again. If we were to rely on any single remedy or procedure in the treatment of this class of cases, *cleanliness* would stand paramount. Cleanliness, or so-called antisepsis, has revolutionized surgery, and it is the most important principle in the treatment of this disease.

The syringe and warm water has many advocates for the removal of pus from the middle ear and meatus; but it always leaves a small quantity of water in the middle ear, which forms a source for a continued suppuration, since moisture is always a prerequisite for suppuration.

A small pledget of cotton wrapped on a smooth probe can be used to cleanse the meatus and also the middle ear if the perforation is large and leave the parts in a perfectly dry condition. This treatment should be repeated daily by the surgeon himself until the discharge ceases.

The use of so-called astringents poured into the ear are objectionable, on the ground that they act as irritants and leave the diseased parts in a moist condition.

If a discharge of pus is kept up, on account of a minute point of necrosis of bone, the instillation of nitrate of silver, sul. zinc, tannin, etc., cannot possibly have any curative effect.

The employment of dry substances, viz., Fuller's mineral earth, powdered boric acid, may act as absorbents in certain cases, but we need not expect much from their local action; on the contrary, the writer has seen many cases that were almost cured (treatment, simple cleansing with absorbent cotton) break out anew and discharge profusely on the use of an astringent application.

If boracic acid is to be employed after the cleansing process seems to fail, none but "Morson's" impalpable powder should be used. A little of the powder is put into the external auditory meatus and by means of a pledget of cotton wrapped on a probe it is pushed well down and the entire meatus well packed. This process should be repeated as soon as the powder is dissolved by the discharge, otherwise it may be allowed to remain until it crumbles away on its own accord.

Boro-glyceride can be recommended, since if it does no good it can do no harm—it is a very bland preparation.

Bichloride of mercury in solution has been used, but cannot be recommended.

If a discharge is kept up and the meatus and middle ear found to contain a small polypus or a granular mass of tissue, a cure cannot take place until this tissue is destroyed, either by chromic acid or by evulsion. Few, if any, cases fail to yield to this simple procedure.

Treatment of the pharynx, if it is found necessary in these cases, must not be neglected.

The inflation of the middle ear by means of the Pollitzer air-bag after each treatment is indispensable.

If the disease is of recent origin, or the pathological changes have not been too great, a fair amount of hearing can be regained. An opening through the membrana tympani, other things being equal, need not materially impair the power of hearing, since this membrane acts, not so much as a transmitter, as a protector to the middle ear. The loss of hearing is in proportion to the disturbance caused in the middle ear, and the more nearly we are able to restore these parts to their normal condition, the better will be our chances for normal hearing.

Treat the disease thoroughly and as early as possible.

393 Elm Street.

◆

BELLADONNA IN THE STERILITY OF FEMALES. –Dr. John Harris Jones, L.R.C.P. (Edin.) of Wilkesbarre, Pa., says that there are few drugs which exhibit so pronounced a predilection to act upon certain structures of the body as belladonna. (*N. Y. Med. Jour.*, Aug. 21, 1886:)—Among its favorite tissues, those of the female sexual organs may be mentioned. Its employment is followed by more or less benefit in every disease to which these parts are liable. I suppose it has fallen to the lot of almost every practitioner to be consulted by married women who never were pregnant, as to the cause of their barrenness. Apparently they enjoy the best of health, and have never suffered from any irregularity of the sexual apparatus. To such I have on several occasions prescribed belladonna internally, and have found that, after taking the medicine for some weeks, they became pregnant. I have seen this happen so often that I am constrained to regard the occurrence as something more than accidental. I shall not venture to theorize upon its action, but will merely mention that I have observed that the external genitalia became more relaxed, and the os and cervix uteri somewhat softened and pliable, during the treatment.

RAPID OVARIOTOMY.—Lawson Tait, speaking of ovariotomy, said: "If it takes a man longer than thirty-five minutes to perform an ovariotomy, he should never attempt to do one."—(Ouchterlony in *Progress.*)

EDITORIAL.

A. B. THRASHER, M.A., M.D., Editor.

QUACKERY.

We had recent occasion to refer to the "Faith Cure" in language of doubt.

Americans are peculiarly susceptible to every form of quackery in medicine.

There seems to be a chance of getting something tangible for the money when the medical adviser appears under the name of "Homeopath," "Allopath," "Hydropath," "Vitopath," etc. A man sometimes gains a great reputation in the cure of certain diseases by industriously and persistently saying that he can cure such diseases. Perhaps the public cannot discriminate between doctors. The laws on our statute books may say that only such persons may practice medicine as have been properly qualified, and with this the majority of people are contented. In Cincinnati these laws are a dead letter. There is now, however, an effort toward organization for the purpose of enforcing the laws in this direction, which bids fair to produce some results. Physicians as a rule are rather loth to take the initiatory steps in such matters because as a matter of fact they are less affected by wholesale quackery than the general public. However, physicians should remember that they owe something to the State, and any effort toward a suppression of quackery in Cincinnati should meet with nothing but encouragement by the profession.

RARE DISEASE. — At the recent Cincinnati meeting of the American Humane Association, Mr. Angell, President of the Massachusetts Humane Society, said there were one hundred chances for a person to be struck by lightning to one of dying of hydrophobia. The general secretary reported that there have been no deaths among human beings during the year 1885 from causes classed as hydrophobia, in America.

PHYSICAL CULTURE FOR WOMEN.—There has been opened in Cincinnati, in connection with the school of Miss Storer and Miss

Lupton, a school for physical culture for girls and women, under the direct supervision of Dr. Mary E. Osborn. There is a properly equipped gymnasium and the exercise will be taken as directed by Dr. Osborn, so that the best results may be attained. This is certainly a move in the right direction. Many times it will be better for the family physician to prescribe a course in this gymnasium than a visit to the mountains or seaside, or a course of medicine.

THE following is the number of matriculants entered at the various medical schools of Germany during the Summer Semester of 1886:

Vienna	2147
Graz	407
Innsbruck	170
Munich	1304
Berlin	1175
Dorpat	862
Würzberg	829
Liepzig	690
Freiburg	585
Griefswald	461
Breslau	391
Bonn	349
Halle	329
Marburg	300
Kônigsburg	267
Heidelberg	266
Kiel	261
Bern	203
Griessen	140
Basel	121
Geneva	118
Jena	114
Rostock	100

JEFFERSON MEDICAL COLLEGE.—It has been but a short time since the Board of Health of West Virgina refused to register the diplomas of Jefferson Medical College. More recently the Professors have placed themselves in the position of antagonizing the International Medical Congress. Whatever caste they may lose by their low standard of scholarship they seem to desire to make up by a "holier than thou" air towards other American physicians.

Our friend, Dr. Reynolds, of "Progress," has had a spicy controversy with the dean of Jefferson, in which the animus of the Jefferson authorities is probably exposed.

It remains to be seen whether even as well established a school as this can afford to disregard the feelings of the great body of American physicians.

◆

SURGEON GENERAL U. S. A.—The President on November 18 appointed Lieutenant-Colonel John Moore, Assistant Medical Purveyor, to be Surgeon-General of the Army. Dr. Moore is a native of Indiana, and entered the service as Assistant Surgeon in June, 1853, and after doing duty in Florida and in the Utah Expedition of 1857, he was ordered in 1861 to the Marine Hospital at Cincinnati. In June, 1862 he was promoted to be Surgeon and was assigned to duty as Medical Director of the Grand Central Division of the Army of the Potomac. In May, 1863 he was transferred to the West and was appointed Medical Director of the Department, and served with the Army of the Tennessee at the close of the siege of Vicksburg. He served through the campaign ending in the capture of Atlanta. He accompanied General Sherman's grand army on the famous march to the sea and through the Carolinas.

Subsequent to the war he served as Medical Director of the Department of Mississippi; was on duty in New York as a member of the Army Medical Examining Board. He was Medical Director of the Department of Texas and of the Columbia. He was promoted Assistant Medical Purveyor, with the rank of Lieutenant Colonel, Oct. 8, 1883, which rank he now holds and is stationed in San Francisco, Cal. He was brevetted Lieutenant-Colonel for gallant and meritorious services in the Atlanta campaign, and Colonel for faithful and meritorious services during the war.

It has been stated that Dr. Moore was not an applicant for the Surgeon-Generalship, but that his excellent record and proved executive ability have probably commended him to the favorable notice of the President. He can hold the office for four years before he will be eligible for retirement on age. He has been ordered to report at Washington at once.—*Med. News.*

MISCELLANY.

THE CONTAGION OF PHTHISIS.

"The little village of C—— is a most healthy spot, being in the neighborhood of two thousand feet above the level of the sea. Epidemics are there unknown, and the inhabitants of this village generally die of old age or pneumonia. In 1872 a young man, who had contracted bronchitis while a prisoner in Germany during the war, settled down in this village. He married a strong, healthy girl; soon afterward he began to spit blood, and died of consumption two months after the birth of a son, and within a year of his marriage. Soon after his death his wife, who had nursed him, had bronchitis, which became chronic, and in a little while tuberculosis of the lungs was manifested. The child had successive attacks of bronchitis and rapidly developed consumption. Cavities formed in the woman's lungs, and she expectorated abundantly. A short time ago the physician attending her was called to a young woman in the same village who showed evident signs of pulmonary phthisis. The house was at some distance from that of the first female patient. The second patient was a woman, twenty-nine years of age, and of a robust constitution. A careful examination revealed that she rarely went to the house of her neighbor who had contracted consumption, and never ate nor slept there, but that she had eaten the flesh of eleven fowls which had died at her invalid neighbor's during the space of four months. She had eaten them very underdone, believing that they were most nourishing when but slightly cooked. It was discovered that these fowls had swallowed some of the sputa expectorated by the first patient. The birds had been seen to collect round her whenever she coughed. On making a necropsy of one of the fowls which had just died, it was found that the intestines and liver were filled with tubercles. The fowl had become very emaciated, and could hardly move; the purulent liquid found in the tubercles contained in the liver was filled with bacilli tuberculosis. It was probable that the other birds had perished from the same cause. These fowls must, therefore," says Dr. de Lemaileree, "have been the means of conveying contagion to the second woman who had eaten them. In this case there is the triple contagion of tuberculosis: First, from man to man; second, from man to animals; third, from animals to man."—*N. Y. Med. Record.*

THE NURSING OF CHILDREN BY THEIR MOTHERS.—(*Jahrb. f. Kinderh.* [from *Prog. Med.*, 1885], xxiv., 3.)

Physicians are believed to be too lax in their duty of urging mothers to nurse their children. In Paris more than half of the mothers evade this maternal duty. The contra-indications to the nursing of a child by its mother are very few. Anemia, emaciation, and weakness on the part of the mother do not, as a rule, furnish her with a valid excuse for refusing to nurse her child. On the cnotrary, the mother's general condition improves, in many cases, during the period of lactation. Neither nervous derangements, with the exceptions of the severe forms of epilepsy, and hystero-epilepsy, or even scrofula, contra-indicate nursing by the mother, while syphilis should never furnish an excuse. Tuberculosis, Bright's disease, diabetes, and some other serious conditions may serve as contradictions. During the first year of life a child should receive no other form of nourishment than mother's milk, and it would be very advantageous to continue this means six months longer.

A NEW PRINCIPLE IN THE TREATMENT OF PARASITIC SKIN DISEASE.—Dr. Alfred W. Perry, of San Francisco, Cal., writes: "The disappointment and delays with which I have met in treating and curing even small areas of tinea circinata, sycosis, and tinea tonsurans, have led me to investigate the cause, and I believe that I have discovered not a new remedy, but the true principle of the application of old remedies. The parasiticides are all active enough to kill the parasite when brought in contact. The cause of failure is the vehicle used. The various remedies are used in alcoholic, watery, benzine, benzol, or oleic-acid solutions, or else mixed in fine powder in ointments. The parasite exists deep in the skin, in the hair or other follicles, or between the epithelial scales. The skin is so charged with the natural fatty sebaceous secretion that it repels watery and alcoholic solutions; these cannot penetrate a follicle filled with fat. The oleic-acid solutions and ointments are not repelled; but they only penetrate the skin after much rubbing and kneading, with simultaneous epilation. A vehicle must be used which will dissolve the sebaceous matter of the skin, and also the remedy. Ether dissolves bichloride of mercury and iodine. Iodine is soluble in turpentine and benzine. I prefer the bichloride of mercury in ether, two grains to one ounce. Iodine oxidizes quickly in turpentine and slowly in benzine, while the bichloride always remains active.

"Any of these solutions, holding a parasiticide in solution, when applied to the skin, will wet or adhere to the skin perfectly, will penetrate between the epidermic epithelial scales, and into the hair and sebaceous follicles, carrying the parasiticide and dissolving the fatty secretion.

"Theory has led me to this line of treatment, of which practice has shown me the great benefit. To apply the bichloride solution in ether, use a small brush over the affected surface, two or three consecutive days, then wait for the slight irritation to subside, applying any bland ointment. There are many remedies which dissolve in the fat solvents—naphthaline, thymol, carbolic acid, chloral, salicylic acid—and these may be suited to individual cases or circumstances."—*N. Y. Med. Record.*

SANITARY MATTERS.—Dr. Thos. W. Harvey in the *Medical and Surgical Reporter*, has an article entitled 'The Doctor as a Sanitarian," from which we cull the following excellent advice to the general practitioner:

"There are a few cardinal principles that should guide his search.

"Whatever changes the air that we breathe from its natural condition is an impurity.

"The same proposition holds good as to food and drink.

"The most useful disinfectants are the sunlight, the oxygen of the air, and pure water. Dilutions is nature's method for purifying the air, aerations for purifying the water.

"Whatever is a source of impurity to the air we breathe renders us liable to disease by depressing the vital forces and weakening the normal resisting power of the individual tissue cells. The same is true of impurities in water or food.

"Any system of sewage collection, carriage, storage, or disposal that does not prove for thorough ventilation and flushing both with air and water, and giving plentiful opportunity for cleansing, is faulty. The mechanism is unimportant, so the object sought is well recognized, which is not the getting rid of the waste of animal life in the speediest manner possible, but the return to its original elements of the products of the decomposition of this animal waste in such a rapid and complete way that it may not add impurities to our air and water, or food."

HYPODERMIC SYRINGE AND INSTRUMENTS.—It is astonishing how few know how to keep this useful little instrument in good order and ready at any moment for use. How often have I heard practitioners say, "I would have made a subcutaneous injection, but my syringe would not work."

If the leather on the piston becomes dry—which it should never be allowed to do—soften it in cold water, *never* in warm. Leather should always be softened in cold water; then soak it well in glycerine. If you put your syringe away, expecting not to use it for several months, put a few drops of glycerin into the syringe. Do the same with your aspirator. When you want it, it is ready, for the leather has been kept soft. After having used your syringe, clean with water, unscrew the needle canula, and before putting the wire into the canula again run it several times through a flame to evaporate all moisture. Always keep the point of your needle canulas sharp.

To keep your instrument bright and free from rust, spread a little ungt. hydr. on a piece of chamois skin; after having washed and dried the instrument, rub over with the prepared chamois.—Edward Borck, M.D., in *Archives.*

REUNION OF SEVERED FINGERS.—Referring to a case of Dr. Souther, reported in the *Boston Medical and Surgical Journal,* and quoted in *The Medical Record* of October 23d, Dr. J. J. Morrissey, of Hartford, Conn., reports the following: "A young man had the misfortune to have his thumb amputated by a hay-cutter, as cleanly as if it were done by the keenest knife. Fully recognizing the importance of the thumb, as the man was a printer, I approximated the parts as closely as possible, yet with little hope of obtaining a good result. I afterward adjusted a splint, and the healing process took place almost immediately. In the course of a month he was able to return to his work, and now, eight months later, he has the perfect use of his thumb. I confess that I did not hope for such a gratifying result, and it was only as a sort of experiment that I first joined the dissevered parts.—*N. Y. Medical Record.*

BOOK REVIEWS.

BOOKS AND PAMPHLETS RECEIVED.

THE MECHANISM OF INDIRECT FRACTURES OF THE SKULL:

By Charles W. Dulles, M. D., fellow of the College of Physicians and of the Academy of Surgery, of Philadelphia, etc. Philadelphia: P. Blakiston, Son & Co.

This is a paper bound reprint from the Transactions of the College of Physicians, Philadelphia. It is a complete monograph on this subject and beautifully illustrated by means of twenty-seven carefully prepared plates. The subject is treated under the following heads: Historical study; Elastic properties of the skull; Anatomical peculiarities of the skull; Architectonic peculiarities of the skull; Influence of soft parts and contents of the skull; Study of cases; Conclusion; Bibliography; Illustrations.

PHYSICIANS VISITING LIST.—LINDSAY & BLAKISTON'S:

For 25 Patients Weekly, $1 00.
" 50 " " $1 25.
" 75 " " $1 50.
" 50 " " 2 vols. Jan. to June and July to December - - - - - $2 50
" 100 " " 2 vols. Jan. to June and July to December - - - - - $3 00.

This is the one we use ourselves. P. Blakiston, Son & Co., Philadelphia. Robert Clarke & Co., Cincinnati.

EARLY DIAGNOSIS OF PREGNANCY:

By E. S. McKee, M.D., Cincinnati. Read in the Section of Obstetrics at the 37th Annual meeting of American Medical Association, St. Louis. Reprint from the Journal of the American Medical Association, Nov. 1886.

THE SURGERY OF THE PANCREAS, AS BASED UPON EXPERIMENTS AND CLINICAL RESEARCHES:

By N. Senn, M. D., Milwaukee, Wis. Reprint from the Transactions of the American Surgical Association, 1886.

HOSPITALS FOR THE SICK: THEIR CONSTRUCTION AND MANAGEMENT:

By Dr. P. S. Conner, Cincinnati. Reprint from the Proceedings of the Thirteenth National Conference of Charities and Correction, held at St. Paul, Minn., July, 1886.

HYDROBROMIC ETHER, OR BROMIDE OF ETHYL AS AN ANÆSTHETIC:

By Laurence Turnball, M.D., Ph. G., of Philadelphia.

Report from the Journal of the American Medical Association, Nov. 21, 1885.

RHEUMATIC DIFFERENTIALS:

By G. W. McCaskey, M.D., Ft. Wayne, Ind. Read before the Indiana State Medical Society, Indianapolis, May, 1886. Reprint from Gaillard's Medical Journal.

CONSANGUINITY IN MARRIAGE:

By E. S. McKee, M.D., Cincinnati. Read before the Ohio State Medical Society, Akron, 1886. Reprint from the N. Y. Medical Record.

◆

QUININE AS AN ANAPHRODISIAC.—Dr. John A. McKinnon, of Selma, Ala., has found in his practice that the continuous use of sulphate of quinine will reduce the venereal desire, and in cases of old age it will destroy the animal propensity completely. He says that he has had cases under observation for several years who took from five to twenty grains daily, not for antimalarial purposes, but because they had formed the quinine habit, and he has found on inquiry of such patients that the venereal desire in them was diminished, impaired, or destroyed. In most cases the subjects would become alarmed at their condition and ask for relief. In the treatment of gonorrhœa in this malarious section, Dr. McKinnon often administers quinine in the inflammatory stage, for the dual purpose of counteracting any malarial complication and to control chordee. It must for this purpose be administered in not less than ten-grain doses at proper intervals, and it acts, he writes, in this respect more satisfactorily than camphor, lupuline, or the bromides.—*N. Y. Medical Record.*

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, December, 1886. No. 3.

DENTAL DEPARTMENT.

ABSTRACTS.

TEETH WITH EXPOSED PULPS.

"Enter an individual in distress, either desiring extraction or relief from pain by 'killing the nerve.' * * * * * * I find an exposed pulp. The patient gives a history of continuous pain for a considerable period, and as I pass a spoon excavator over the exposure, slightly enlarging it, I discover an oozing of pus. The indication to me is to devitalize immedately," etc.

The indications to most of us would be that devitalization had already taken place in the body of the pulp. Do tissues decompose before they die? If death be not already complete to the end of the root or roots in such a case, is it not a fact that it is only a question of a few hours or days of time when a line of demarkation and practical separation will exist between such root filaments and the dental nerve?

Why does the pus ooze forth? Because it is under pressure.

Why was the patient "in distress" when he entered? Because the pressure was then being exerted upon sensitive tissue at the point of least resistence, viz., the apical foramen.

Why is it relief is experienced by the "individual in distress?"

Because a point of *no* resistance has been made by the excavator.

Why is it that common questions, explained by the simplest principles of hydrostatics, must be continually repeated? Echo!

Why is it that the application of a drug or drugs in proximity with decomposing tissue should be thought to give instant relief to sensitive tissue beyond?

The author says that "in many cases the sudden cessation from agonizing pain is marvelous," as he supposed, from the application of the drug. Evidently the use of the drug in the case cited had nothing to do with the results named. We have all seen the same consequences from the simple relief of pressure, many, many times. All the dead and dying tissue needs is free vent and a little time. Ninety-nine times in a hundred the whole pulp will die; the lie of separation between dead and living tissue will be at the constricted portion of the canal, at the apex of the root, if *you give it time*. The sensitiveness supposed to exist *in* the pulp is beyond it. It is excited by pushing the pulp, which causes pressure. It is excited also by pulling on the pulp, in attemps to remove it before sufficient time has elapsed for complete separation. The dead tissue pulls upon the living nerve filament at or beyond the apex.

The doctor's directions to use cocaine and canabis indica to make the extraction of *dead* pulps by peacemeal easy seem to be unnecessary, and the theory of the persistent vitality of the lining membrane of the pulp-chamber, after the death of its occupant, is one to which we cannot subscribe.

The advice as to the use of drills and burs in root canals will not, I hope, be generally followed. If a root canal be so small that the most delicate jeweler's broach may not enter it, surely no instrument coarse enough to be driven by an engine can be trusted to follow in its path. A small bur may be used to give freer access to a canal, to give it a funnel-shaped opening where we can see it, but beyond that, as a rule, the canal should be left in its natural state. A fine, flexible, drawn-tempered jeweler's broach, delicately manipulated, will find any canal that can be found, and follow it to the end; cotton fibres sufficient for cleansing may be carried with it in nerrly all cases. With or without the cotton, enough eugenol, or some other agent, may be inserted to thoroughly disinfect. When the attempt is made to enlarge the canal beyond a certain point with drills and reamers, it is all guess-work.

If the canal deviates from a straight line, as it frequently does, the drill may not follow. It may strike it again or not.

A flexible, smooth broach does follow the canal; there is certainty, and not guess-work. It will also carry a semi-liquid filling, ilke gutta percha in chloroform, along the glassy walls of the canal to the very apex, and seal the same with a non-absorbent, indestructible material. The least sensation of consciousness on the part of the patient is an indication to the operator when the end is reached. It is absolutely impossible with any instrument to carry gold or tin foil into such canals with any definite certainty. The canals cannot be so filled without enlargement, and enlargement is uncertain.

In most cases, after using the fluid as aforesaid to seal the apex and narrower portion, a gutta percha cone of proper size and length may be used to complete the filling with certainty. When root canals have been thus found, cleansed and filled, whether it be one or four, the operator has a sense of satisfaction in work well done such as he can never experience by less certain methods. —Garrett Newkirk, M.D., in *Independent Practitioner.*

THE IMPLANTATION OF TEETH.

A Novel Operation in Dental Surgery.

* * * Concerning the operations of Dr. Wm. J. Younger, of San Francisco, performed in New York, Philadelphia and Boston, we have no personal knowledge, but we are assured that they so far seem successful. It appears to be established by sufficient testimony that a patient was presented in New York for whom had been implanted a tooth in an artificial socket more than a year previous, and it was impossible to detect any marked difference between it and its natural neighbors.

Of the clinic in Buffalo, given in Dr. W. C. Bartlett's office, upon a patient of Dr. B.'s selection, and in the presence of Dr. Park, professor of surgery in the University of Buffalo, and a number of Buffalo dentists, Dr. Bartlett says he can speak knowingly. Dr. Younger labored under disadvantages, for not knowing what was wanted, nothing had been prepared for him. The patient was a young man, a student in the medical college. Nearly a year before, he had lost the right inferior second bicuspid, and it was proposed to insert a tooth in its place. Not a trace of the socket remained, and there was considerable absorption of the alveolus, which made necessary a tooth with a long crown. None such could readily be found, until Dr. Younger himself visited the office of one who extracts a great many teeth, when, out of a bushel or more of dried up, long extraeted dental organs, he found one which the donor said had rested in the dental Golgotha at least three years, among thousands of its foul companions. This was carefully prepared by removing the debris from the pulp chamber and canal, thoroughly disinfecting it with a one to one thousand solution of bichloride of mercury, and filling the root with gutta percha. It was then left in a warm solution of the corrosive sublimate while the socket was prepared.

This was accomplished by carefully dissecting back the gum, and with a small trephine boring a hole in the alveolus, which was enlarged to the proper size and shape with burs. The tooth was occasionally tried in the socket to determine the proper direction, size and depth, and when these were secured it was forced down to its proper position and left there, the socket having been previously thoroughly syringed out to remove all debris. Its perfect occlusion was now secured by dressing down the cusps a little, when the case was dismissed. So accurate was the fit that the tooth was held firmly in position by mechanical adaption alone, and no ligatures or other appliances were used to retain it. The occlusion with the superior tooth was of course sufficient to prevent its rising in the socket. No after treatment was recommended but the whole thing was left to the care of nature. The operation was dexterously performed, the occlusion was perfect, and the pain experienced by the patient was not greater than that necessary in filling a cavity in a rather sensitive living tooth.

At this present writing the tooth has been in position about a week, and aside from a very little soreness, the necessary result of the wound, there have been no bad symptoms and the case appears to be progressing favorably. Of course the time is not sufficient to afford any reliable index of what the final result will be, and had we not credible testimony that cases analogous to this have gone on to apparent success for a year or more, it would not be quoted. As, however, the operation is attracting some attention in the profession, we have thought is not out of place to detail the manner of its performance, reserving the right to report further upon this instance at a subsequent day.

If this operation should prove to be a feasible and successful one, it will certainly require the revision of our ideas of physiological law. It must not, however, be understood that we are committed to it or are fully convinced that it is a practice which may unhesitatingly be commended. We are content to wait further developments. And yet, if a smooth ivory peg be driven into the bone and in time encapsulated within the tissue, or perhaps united to the circumjacent bone, why is it not possible for a tooth to be made to grow in an artificial socket? We know that the spongy portions of the maxillæ are the most accommodating of the bodily tissues, and will submit to almost any surgical or traumatic interference and yet return to a state of health. We also know that the proliferation of bone corpuscles is not entirely dependent upon periosteum, but that cavities artifically made in bones will be healed from the bottom by granulation. In numerous instances we have replanted teeth that have been out for many hours, and some of these have remained in good condition for ten years and are seemingly perfect yet. At the present time there is under our care the case of a boy of eight years of age, whose central incisor was knocked out and practically remained out for more than forty hours. The tooth was incomplete in growth, and there was nothing like a finished foramen, the end being open the full size of the root. Yet this was inserted, after proper preparation, and now, three weeks and more after the accident, it appears to be well united and comparatively solid and healthy. But all this is but little analogous to the implantation of foreign teeth in artificial sockets.

Dr. Younger is careful to select teeth the roots of which are apparently covered with pericementum, no matter in what a desiccated condition this may be. He believes in the persistent vitality of this membrane. Although we are aware that membraneous tissue differs from most of the other tissues of the body in the readiness with which its presence, even when long dead, is tolerated, as is evidenced by its occasional use in surgery, we cannot believe that it is because it has retained any vitality. This seems to us absurd. That Dr. Younger has made his only failures, according to his own statement, in the insertion of teeth that were without the dried pericemental membrane, may be due to the fact that it may act as a protection to the primary deposition of protoplasmic matter, which finds a resting place in its meshes, and thus acts like the cells of the sponge in artificial grafting.

It would be interesting to determine just what is the nature of the relation of the tooth and bone in these implanted cases—whether a pericemental membrane is formed and the organ held in position in the usual way, or whether there is a solid, bony union. That it is not a merely mechanical adhesion seems abundantly proved, for in some of Dr. Younger's cases the gum has been perfectly adherent to the neck of the tooth. It is to be hoped that, at some time, some of those implanted teeth that seem entirely healthy may be extracted and critically examined, for we think it must be admitted that a union of some kind has really been established between teeth long extracted and the walls of artificially formed sockets.—*Independent Practitioner.*

[If Dr. Barrett's speculation as to the possibility of there being a "solid bony union" between the implanted tooth and the alveolar walls, should prove correct, we suspect dynamite would be required to remove the tooth.—ED.

EDITORIAL.

THE PRINCIPLES INVOLVED IN THE HERBST METHOD OF FILLING TEETH.

The editor was disappointed in his purpose of attending the American Dental Association, and so cannot express himself with the confidence concerning Dr. Herbst's method of filling teeth that seems to mark the declared opinions of several who saw the master himself operate. We have sent out "feelers" to men prominent in the profession, in the shape of letters requesting opinions for publication, but thus far the "trumpet yields an uncertain sound." No one seems quite prepared to say what he thinks of Dr. Herbst's method. Experiments made both in and out of the mouth have led us to inquire into the fundamental principles involved in the new method of welding gold, and give rise to various speculations. First of all, the question arises, is the gold welded? —made to cohere? or adhere? (not to confine ourselves to definitions). If it is welded, what new principle is this whereby, in defiance of a generally accepted principle in working gold foil, a *mass* of annealed gold is placed in a cavity and forced down solidly into a compact coherent body,—a body uniformerly condensed throughout? We would not expect, by heavy malleting, to thoroughly condense the same bulk of annealed gold placed at one time in a cavity. Has Prof. Tyndall's theory respecting heat as a mode of motion anything to do with the hypothesis that the molecules of gold move one upon another under a rotating instrument plied with sufficient force to evolve heat? And would such movement be favorable to a re-arrangement of the molecules, resulting in actual cohesion? These are questions the answer to which we have sought for in vain, in various works on molecular motion. On first thought we were inclined to believe that Dr. Herbst had unconsciously added to our own Dr. Atkinson's laurels, by a novel illustration of the efficacy of malleting. We observe first that theoretically, the revolving point,—cylinder—bulb,—is but a modification of the mallet.

The peripheral boundary of the bulb-pointed or "roof"-pointed instrument used by Herbst, is of course a circle. Euclid defines a circle as "a polygon having an infinite number of sides." Theoretically then, the revolving point brings to bear upon the filling an infinite number of plane surfaces, like so many little hammers beating upon it. Practically, however, this beating, as we understand it, simply resolves itself into friction. Is this friction—whatever its nature may be—effective in condensing the gold? Beyond question, yes. Whether the imperceptible heat evolved by the comparatively light pressure of the instrument plays any part in the result claimed of causing cohesion, is perhaps an open question.

* * * *

In experiments made by the writer, of applying all possible pressure,—pressure sufficient to stop the instrument from revolving,—no appreciable amount of heat was evolved. Still, it is stated that Dr. Herbst sometimes heats the tooth sufficiently to attract the notice of the patient. This seems hardly consistent with his instructions to apply the instrument with intermittent motions, and while revolving rather slowly. If latent heat plays any part in effecting cohesion, one would expect, by following his directions, to accomplish only a rather superior condensation of the gold. And this only is what we suspect is actually accomplished. The suggestion that the finishing layers should be of cohesive gold applied with the foot-plugger and mallet, looks to the unprejudiced note-taker like an admission that the rotary method is not all-sufficient.

* * *

The claim that Dr. Herbst's method involves no new principle, and that an American dentist more than twenty years ago called attention to the fact that gold could be condensed and welded in a cavity by burnishing, should not be admitted as detracting in the least either from the credit due our German friend, or from the importance of thoroughly testing his method. Many a successful invention has been founded upon principles recognized but not fully appreciated by investigators who failed to develop their highest value. The expansive force of steam was known long before the idea of making practical use of it occurred to any one, and Hero constructed a steam toy 250 years before Christ and more than 2000 years before Watt took out his patent for the first steam road-carriage.

* * *

That gold cylinders, especially if new and fresh, can be compressed by Herbst's method into a cavity until it is full, and made sufficiently resistive to withstand a considerable lateral strain, any-one may easily demonstrate to his satisfaction. Any old bur broken off, may be used, if the end of the shank be ground off, square and smooth. We have succeeded with a ball burnisher and either Wolrab's or Williams' *un*-annealed cylinder, in building up a surface projecting one-eighth of an inch above the level surface of the tooth, so strong as to resist persistent attempts to break it off with a strong hatchet excavator. The end or the side of the revolving instrument may be used. Touch the burnisher occasionally to a crocus strip held in the hand, if it becomes gilded. This method of filling many cavities seems at least equal to the best methods practiced with strictly non-cohesive gold in strips, or hand-made cylinders. In all those cases where many operators fill the cavity two-thirds full by stuffing and wedging soft foil, and finish with cohesive foil, depending upon special retaining grooves for holding the latter, the new method would seem to possess the highest commendable qualities. We are not quite convinced however, that the operator can always be sure of a tight joint secured at an inaccessible cervical border, unless he uses every precaution to prevent moving of the first layers from the remote edges. The revolving instrument can not be applied to all points simultaneously so as to press the mass down as a single body without the possibility of recoil at any point. By virtue of the instrument's burrowing into and spreading the gold in the act of condensing it, it would seem to nearly approach our ideal of perfection in this respect, it must be admitted. Nor do we believe the method can be used for condensing gold against frail walls with any mystical effect in the way of preserving such walls from the danger of breaking and falling away. It was at one time claimed as one of the superior virtues of heavy foil; that it could be "built over" frail edges so as to protect them from fracture. How well founded this claim was, few need to inquire. * * *

We recently compared a filling made with agate points (by a friend in the profession) with one inserted by malleting. The cavities were of the same size and shape, and the fillings both appeared perfect at the edges. Having broken the tooth and removed the fillings *en masse*, it was apparent upon careful inspection that the malleted filling had not taken as perfect an impression of the cavity as had the other, although we do not think either would have leaked. The malleted filling was considerably more tenacious than the other, as appeared on an attempt to cut through it with a knife applied in the line of "cleavage," if we may use the word. For those who believe that extreme density is the main requisite in many fillings not exposed to danger from a lateral strain, experiments with the new method are to be recommended. * *

The Herbst method certainly possesses several important features that ought to commend it to the attention of every one who is unselfishly devoted to the purpose of attaining the highest possible perfection under any and all circumstances, in filling teeth. It is too early to claim that it does fulfill all required conditions, but it points in that direction. Putting aside the question of perfect adaptation of gold at remote points of cavities, it seems certain that the principle of condensing by means of a rotating instrument greatly diminishes if it does not entirely obviate the danger of fracturing borders, either when commencing or finishing a filling. If the new method proves, upon thorough trial, to have enduring merit, its establishment ought to bring a thrill of joy to the hearts of the anti-amalgam wing of the profession, notwithstanding it may lessen the gap between the exceptionally skillful operator and those whom he has held to be his inferiors in that respect.

ISINGLASS FOR MATRIX.—Plate mica, commonly called isinglass, has been found by the writer to be peculiarly well adapted for matrices for amalgam and gutta percha fillings. It is easily shaped, is sufficiently pliable to bend around the cavity, and being very smooth is not liable to drag away the filling material with it on being removed. S. J. SPENCER, San Francisco.

MISCELLANEOUS.

OLD SAWS THAT OUGHT TO BE FILED—(AWAY).

The distinction between cohesive and non-cohesive, hard and soft, etc., as applied to gold foils, ought to be fairly well understood by this time. It seems to be hardly worth any dentist's while to travel two or three hundred miles to get to a dental convention in order to occupy valuable time in explaining the use of these terms.

* * *

The next man who offers to get up in a dental society meeting and explain the difference between an antiseptic and a disinfectant deserves to have a hole bored through him with a big Herbst burnisher.

* * *

Let a subscription be started for another Bartholdi statue to be erected to the memory of the dentist who never had a failure in capping pulps.

* * *

The dentist who fills every root to its apex with gold will need no other monument than that erected by his own hands.— (when the profession in general come to realize the miraculous nature of his achievement.)

* * *

In all that has been written upon the subject of dental education, we have seen no suggestions as to means for reforming the man who interrupts an interesting discussion with something or other entirely foreign to the subject under consideration by the dental society.

* * *

The progressive dentist's cabinet case is frequently like an apartment in the U. S. Patent Office—full of ingenious appliances curious to look at, but of little practical utility.

* * *

This is not an old saw: Dr. McKellops of St. Louis thinks rapid wedging is a barbarous practice. Good! We agree with Dr. McKellops. Space for filling is better attained by the old fashioned way of slow wedging with tapes, cotton or rubber. Even if the dentist has no regard for the sufferings of his patient, he gains a valuable advantage by adopting merciful means. The cruel dentist no doubt often makes only half a bill, because his timid patients will not come back if they discover that he is careless about inflicting pain when he might avoid it. It is easy to argue that the "gentle" operator is likely to be a poor operator. That argument may prevail within the ranks of the profession itself, but it is not likely to have many ardent supporters among the laity.

A SPECIMEN OF FRENCH DENTISTRY.—Recently a lady called upon us to have two "pivoted" teeth reset. After careful examination we were unable to identify the teeth in question. Having sufficiently enjoyed our perplexity, she directed attention to the two upper lateral incisors, which proved to be human teeth which so exactly matched her own natural teeth as to excite our wonder at the chance, as we deemed it, by which the dentist had succeed in so admirably meeting the requirements of the case. The operations were performed by Dr. Bing of Paris. The lady did not for a long time become aware that they were not manufactured teeth. One of them was considerably decayed on both approximal surfaces. We filled these cavities. A bicuspid was filled on its mesial surface with a plug of oak or hickory wood. This was spongy and "waterlogged," and was completely surrounded by a line of decay. It had been in place four years.

This sounds like an Oriental allegory, but it is strictly true.

THE AMALGAM WAR.—Who can read the records of the so-called "amalgam war," without a pitying contempt for the pitable, arrogant intolerance that refused to test this material, and denounced and dismissed from membership in the American Society of Dental Surgeons honest and earnest men unless they would sign an agreement not to use "the stuff!!" How that blush mantles when I read later on that some of the very men who were denouncing amalgam, or who held their tongues when they should have spoken in its defense, were slyly using it all the time but did not think best to say so for fear of the influence it might exert on the young men of the profession if its use was encouraged.—A. Morseman, Iowa City.

OBITUARY.

E. OSMOND, M. D., D. D. S.

DR. E. OSMOND, of Cincinnati, died Nov. 24th, after a lingering illness. Dr. Osmond was among the older dentists of the city, a graduate of the Ohio Dental College and also, we believe, of the Ohio Medical College. He stood in the ranks of the foremost progressive men in the profession. His devotion to his family was remarked by all who knew him in his home life. At a meeting of the leading dentists of Cincinnati held on the same day, resolutions were adopted expressive of their sense of the loss the profession had sustained. Dr. Osmond was a native of Hereford, Eng.

◆

JOEL P. ULREY, D. D. S.

DR. JOEL P. ULREY died of consumption at his home in Rising Sun, Ind., Nov. 9th. 1886, aged seventy. Dr. Ulrey was a native of Lebanon, O., the home of Tom Corwin, and received his education in that place. He worked at the printers' trade for several years there and in Cincinnati, studying dentistry later in the city. For valuable assistance rendered in establishing the Ohio College of Dental Surgery he was awarded an honorary diploma by that institution. He practiced dentistry about fifty years, and enjoyed the confidence of a large number of patrons in Rising Sun, Aurora, Lawrenceburg, and other places. He was a regular attendant at the annual meeting of the Miss. Valley Dental Association, and had numerous friends in the profession in Cincinnati and other cities.

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, January, 1887. No. 4.

MEDICAL DEPARTMENT.

ASTHMA.

A Clinical Lecture Delivered at the Good Samaritan Hospital, Nov. 9, 1886.

BY JAMES T. WHITTAKER, M.D.
Professor of the Theory and Practice of Medicine in the Medical College of Ohio.

[Stenographic Report by DR. J. M. FRENCH.]

History, read by Dr. Parker, Interne:—J. C., æt. 68, enjoyed perfect health until nine years ago. He then suffered from a severe attack of malarial fever of several weeks' duration. Since that time he has never been fully well. Immediately after the malarial fever he suffered for the most part from gastric trouble, with pyrosis, gastralgia, and occasionally vomiting.

The disease for which he is now being treated came on suddenly at night, about six years ago. He had retired in perfect health but at one o'clock in the morning he was awakened from a sound sleep by an extreme dyspnœa. He felt, as he described it, as though some one were grasping him tightly around the throat. Springing from his bed he ran about the room; he sat down, stood up, and tried various expedients, but got no relief until he finally opened a window and after hanging over the sill in the cold air for awhile, he began to breathe with more ease. For three months these attacks were repeated every night; then they became less frequent. He has, however, never been entirely free from the disease for any considerable length of time. The attacks now come on most frequently after eating indigestible food. In addition to the asthma, since about one year after it came on, he has suffered from frequent attacks of vertigo. His dyspnœa also comes on during the day time upon every exertion, even after ascending a flight of stairs, when he also feels his heart beating violently in the epigastrium. His present weight is 136, normal weight 150 pounds.

His family history is not of much importance. His father died of rheumatism; his mother, as he states, of asthma, his paternal and maternal relatives so far as known, have been healthy. One sister died of asthma.

GENTLEMEN:—We have before us a typical case of asthma. The correctness of this diagnosis is established beyond doubt by the history that has been read. It must strike you as peculiar to see an old man suffering from asthma; for asthma is a disease which as a rule develops in early life. Let us discover, if possible, its cause.

Physical examination.—It is apparent on the most superficial examination that this not a physiological chest. The first thing that would attract your attention is the flatness above the clavicles. Next you observe the immobility of the chest walls. You notice that as he breathes there is no motion at all. The chest moves *en masse;* the respiration is almost entirely abdominal. The thorax is an immobile, fixed casket. It is not, however, a chest that would excite your suspicion of tuberculosis — there is a considerable depression above the clavicles but no depression below, and although there is great emaciation there is no winging of the scapula. There is a stooping forward and a certain amount of lardosis or lateral curvature of the spine. In addition to this he has what is called a barrel shaped chest. This is typical of emphysema; and all the more typical because the individual is emaciated. We can study the chest from an osteological point of view. Then we have had our attention called to the fact that the heart is displaced into the epigastrium. You want to know, of course, when you see a condition like that whether the pulsation is really that of the heart or is caused by a distended stomach, elevated by a violently pulsating aorta. You can readily satisfy yourself of the presence of the heart by auscultation. What does the presence of the heart in this locality signify? Either that the heart has been displaced bodily or that there has been great hypertrophy of the right ventricle. The hypertrophy is greater in this case on account of the individual. If this man were very obese we would see something of a different picture. You could not map out the outlines of the organs of the chest so distinctly. Commonly in emphysematous persons we have a short neck, but the immobility of the chest, the stooping forward, the displacement of the heart as in this case, are all characteristic of the disease.

You will learn a good deal more by listening to the cough. He has given vent several times to a short, suffocative cough. It is a cough that is never deep but always superficial. By it alone you could almost make the diagnosis.

The next thing is to put your hands upon the chest. You can by this means recognize much better its immobility. It scarcely moves under tranquil respiration. Under full respiration I feel a very slight elevation. Sometimes in his case I doubt not you may feel the fremitus of bronchial rales, which you can also sometimes hear at some distance from the patient.

Percussion:—The tone which I elicit by percussion is a resonance difficult to recognize as pathological, without comparing it to the normal tone; but by percussing over the region of the heart I find no dulness, and by mapping out the hepatic region I find that the liver has been displaced downward. The sounds elicited by auscultation are sonorous and sibilant rhonci, varied sometimes by mucous and submucous rales.

Asthma.—When an individual presents himself before you for difficulty of breathing, you desire to learn first whether it be a case of asthma or simply a dyspnœa. Dyspnœa belongs alike to diseases connected with the heart or with the lungs, as well as to many outside causes. Typical asthma begins in the night hours. The individual may go to bed feeling perfectly well or even feeling an over stimulus—a kind of exhiliration. Many who suffer from the disease know how ominous that feeling is. A fewer number feel depressed, they usually suffer from a disturbance of digestion. They go to bed and fall asleep. The sleep may be refreshing at first, and they know nothing more until they find themselves sitting up in bed gasping for breath. They struggle about the room for a time, perhaps, as this man has described to us, then go to the window, and hang out, even the coldest night in winter, for breath. At first the face is florid, then it becomes blue and livid, the eyes protrude, the vessels of the neck throb. There is, moreover, depicted in the face the most extreme anxiety. It is a picture indeed alarming to the bystanders. This attack lasts for an hour or an hour and a half, when the individual finally begins to get his breath.

The difficulty in these cases is not so much in getting air into the lungs as in getting it out. The great effort is in expiration. Sometimes the length of expiration is double that of inspiration.

After the attack the individual recovers and feels quite well; he goes about his business the next day, but the next night is a repetition of the same scene. That is the typical picture. Anything that differs from that picture you want to interrogate very closely. This typical asthma is a disease without a perceptible lesion, so far as we are able to discover. In the case before us, however, I think we have an explanation of the disease. This man might be expected to have shown the disease in early life, because his mother had it and the history tells us that one sister died of it. You must take this statement with a good deal of allowance, for individuals do not die of asthma. Anyhow, if a man has a history of asthma or any other neurosis in his family history, it may be expected to develop in his early life. If it occur later, you want to investigate more especially with reference to its cause, for in asthma, although a man seems well, he is not well, but he suffers all the time from some other underlying affection. If we discover the cause of asthma we are able to treat it, for the man who finds the cause can treat it successfully, but the man who treats it only superfically, that is, in its explosions, will have no permanent success. Now sometimes even in childhood, we find an asthma which we cannot explain except by saying that it is hereditary, but in the vast majority of cases it is only symptomatic.

In arriving at a diagnosis in a case of asthma, the first thing that is to be eliminated is Bright's disease. If the individual has Bright's disease he is liable to uræmia, and we know that one of the most frequent causes of asthma is uræmia. It is then termed an uræmic or renal asthma. That is, too, the worst form of asthma, and over it you will have only the most temporary control. Test the urine for albumen; inquire for headache and vertigo; examine the patient for dropsy about the face and feet. When, then, an elderly man presents himself with asthma, the first thing is to eliminate Bright's disease.

You would next inquire the avocation of the man. If this man had told us that he was a painter instead of a shoemaker, we could have accounted more easily for his asthma. A not infrequent manifestation of lead poisoning is asthma. These patients have most frequently encephalopathies, and among them they may have asthma.

Next most common as a cause of asthma in old men is gout. Gout usually shows itself in a form which is easily recognized. There is a peculiar and severe pain in the great toe. If a man is awakened at night with such a pain, we know that he has gout, but there are a great many mixed cases of gout. We test the urine again in these cases, we find it loaded with uric acid. These patients are usually florid of countenance, not due, however, to full-bloodedness, as has been supposed, but rather to the reverse condition, to a dilated condition of the smaller bloodvessels. Gout does not show itself so frequently with us as it does abroad. In this case it is easy to eliminate gout.

There is one other disease which may produce asthma. It is very uncommon, although represented by a certain class of irregular practitioners as very common, and that is diabetes. Diabetes reveals itself in the urine.

Now if you are able to rule out diabetes, lead poisoning, gout and Bright's disease, you will reach causes which you may be able to remedy. Although you may not be able to cure the diseases which give rise to asthma, you will be able to prevent some of their more aggravating symptoms. First you are to examine for conditions in which there may be pressure upon the vagus nerve. The question in these cases is, is there simply irritation of the pneumogastric nerve? This irritation, especially in childhood, is frequently caused by enlargement of the bronchial glands. Many children thus affected show us an enlargement of the glands on the outside of the body, from which we can at least infer a similar enlargement of those within. The enlargement of the bronchial glands is a condition which should be borne in mind, for it is upon the frequency of this condition that the iodide of potassium has gained a just reputation for the relief of asthma. The relief which it affords depends upon the fact that iodine so quickly resolves and dispels the enlargement of these glands. We are not always able to eliminate this factor; in this case, however, it is eliminated, for these cases occur almost always among children.

We investigate next the stomach of the male and the genital organs of the female. Here is an individual who has suffered for a long time from dyspepsia. There has been all the time, it is safe to say, an inherited hypersensitive condition of the nervous system, but it has never met with a provocative influence until at the time of his first attack of asthma six years ago. The underlying cause is here, I take it, the gastric catarrh.

Look out always in childhood, and more especially in adolescence, for affections of the nose, hypertrophic mucosæ, catarrhal conditions as exciting causes of this neurosis.

Emphysema.—This man has had the asthma so long now that it has produced structural change in his lungs. He informs us that he has not for a long time been entirely free from dyspnœa, which shows itself with every exertion. He is thus incapacitated for work. This shows that there is some organic lesion. It might be on the part of the heart, but the valve sounds are normal, although weak, owing to the fact that the heart is covered with lung tissue. The valve sounds are stronger than in health, though not so distinctly heard, for it requires a greater amount of force to propel the blood through the narrowed capillaries of the lungs. The dilatation of the air vesicles causes a fatty degeneration of the alveolar walls, and they break down, giving us dilatation and coalescence sometimes to the size of a hen's egg. We frequently meet with air vesicles as big as a pea, especially in the upper portions of the lungs, and sometimes they break under the pleura and we find the pleura lifted up by the air under it. To sum up these conditions the heart is displaced, the chest immobile, and there is on percussion a peculiar resonance known as a band-box tone, due to the resistency of the air vesicles, or in part, no doubt, to the resistency of the chest walls. These conditions are not found in any other disease than emphysema. It is most marked in cases in which emphysema is most general. Auscultation would not show us anything of importance except that the lungs extended lower down than normally; the respiratory sounds are more masked. It only shows us signs when bronchitis supervenes. Asthma only disturbs the rythm of respiration, there are no rales peculiar to it. Most cases of asthma are precipitated by a bronchitis. This man would be sure to have an attack after going out into the cold air, and especially if he got himself wet, he says.

Prognosis.—The prognosis in this case is made entirely different by the fact that the asthma has passed over into an emphysema. We might even be able to control the asthma if there were no structural lesion. If the gastric trouble had been properly treated in the first place it is probable that the individual might have escaped the asthma.

Treatment.—The treatment addresses itself first of all to the attack. That is not of much importance in most cases to the physician, for the patient does not employ the physician to treat the attack more than once. The best of all remedies for the treatment of the attack is the hydrate of chloral, in a dose never less than 15 grains nor more than 30 grains. It is generally best to give 20 grains, give it largely diluted. There is nothing better as a vehicle than orange-flower water, as was first suggested by Liebrich. Administer the chloral at any time, but especially before the attack if possible. There are individuals who learn to cut short the attack by simpler means. They who are not accustomed to the use of tobacco smoke a cigar; those who are accustomed to it add some stramonium leaves to it. These remedies are not of much account in most cases. There is one, however, which has recently been introduced and which is a product of tobacco, a highly volatile substance that is worthy of confidence, and that is pyridin. A few drops (5 or 10) of it are let fall upon a hot plate and the individual inhales the vapor from it. It will fail you many times, but in many cases it acts like a charm. Chloroform will cut short an attack of asthma immediately, and so will ether, but these agents cannot be used more than once. Lobelia used to be given, tartar emetic was also formerly used, but they have been abandoned on account of their prostrating effects. In the great majority of cases you will rely upon chloral. Morphia is used, but it is not so good as chloral. These individuals have it always in the house and it soon loses its effect simply because it so soon becomes decomposed in solution. It should be freshly prepared at least every few days. Then in a case of indigestion like this preface it with 10 or 15 drops of hydrochloric acid, because it speedily decomposes in an alkaline solution. This caution will protect the patient with a weak heart.

Now let us treat the underlying condition. That is where the skill of the physician comes in, that is where he makes his reputation. The iodide of sodium will reach very many cases. Give the iodide of sodium, 15 drops of an ounce to ounce solution, three times a day for about three months. In some cases it will do no good, but in many cases it will regulate the disease.

The remedy next in value is quinine, because the disease is sometimes due to malaria. The next remedy is arsenic; next iodine, especially in Bright's disease. But we also protect the man with Bright's disease by keeping the skin dry and warm, which is of the utmost importance. You can sometimes prevent the attacks every night by putting the man into a warm bath heated up from 100° to 110° F. No body can treat the attack better than the man who has the disease and learns to treat it. He can treat it better than you can, for he has rung the changes; but he cannot discover the cause of the disease, and that is often half the cure.

I showed you last week a man who had epileptic convulsions, a middle aged man, and we would not admit true epilepsy as the cause. We struggled with the diagnosis until we found Bright's disease. That man had not had an attack before for a whole year. He will not have another probably, if he can live up to the regime upon which we put him. So here in this case we can probably cure this asthma, which is not a simple asthma, by diet and by hydrochloric acid. Over the emphysema we shall have less control.

◆

EXPLOSIVE MIXTURES. — Chlorate of potassa and sulphur explode readily upon trituration. They should therefore be ground separately, and mixed after.

Lycopodium explodes if any of the dust falls into gas-light. Mix in the daytime.

Hypophosphite of calcium explodes at high temperatures easily.

Oxalate and citrate of calcium explode at high temperature.

Permanganate of potassium and any organic substance explode readily, *almost instantly*, upon being mixed together.

A mixture of chlorate of potassium, glycerine and ferric chloride explode almost instantly if superheated. Leave out glycerine always.

Ozone powders are *very* explosive.

Iodine and ammonia explode easily.

Sulphuric acid and oil of turpentine explode during the manufacture of terebene, a new compound among physicians.—*Nemo in Medical Summary.*

REPORT ON HYGIENE. *

By F. W. LANGDON, M. D., Cincinnati.

MR. PRESIDENT AND GENTLEMEN:—Your committee on Hygiene, appointed October 26th, 1886, have the honor to report herewith: As this is the first formal introduction of the subject for consideration by this society, I have deemed it advisable to limit the *scope* of the present report mainly to the suggestion of some directions which our thoughts on the subject may profitably take, rather than to attempt the elaboration of any especial lines of inquiry.

Hygiene, the science of health, embraces the consideration of all influences which may effect, favorably or unfavorably the health of the individual and hence, through him, that of the community and the race of which he is a unit. The *study* of these influences may be termed *theoretical* hygiene, or in some cases *historical* hygiene; whilst the *application of means* for the production of favorable or the removal of unfavorable influences may be styled *practical hygiene*, also called sanitary science, when the inquiry or action concerns the community as a whole. The chief object of hygiene is the *preservation* of health and the consequent advantage to the community, while therapeutics has for its aim the *restoration* to health of the diseased, which may not, in all cases, inure to the benefit of the community or race as a whole.

Of the two, therefore, hygiene is by far the more important in a politico-economic sense. Professionally considered, however, hygiene is to medical *science*, what thereapeutics is to medical *art*; and, in medical *practice* the two may be said to resemble the blades of a pair of scissors, *of very little use when separated.*

Of the importance of the subject little more need be said. It has been a matter for study and observation, and for legislation, both civil and religious, from the earliest dawn of civilization, and the literature of the early Hebrews, Egyptians, Greeks, Romans, and other nations abounds with references to hygienic and anti-hygienic practices. It is also notorious that the periods in European history during the middle ages, characterized by almost total disregard of hygienic observances, were also the periods of greatest mortality from epidemic disease of which we have any record. The object of hygiene, as already stated, is the *preservation* of health—*not* the development of great physical strength alone, for it is notorious that famous athletes are not healthier, all things considered, than other classes,— but in fact are especially subject to certain diseases *because* of their muscular over-activity. Nor does hygiene contemplate the production of extraordinary *mental* power in the individual—for all machinery wears out faster by increasing its speed and power.

---

*A Paper read before the Cincinnati Medical Society, November 30th, 1886.

Again, *mere longevity*, although it may follow, is by no means a chief object of hygiene, which rather looks to that prolongation of the *active period* of life, in which the individual is of greatest use to the community—in other words hygiene has in view the *postponement rather than prolongation of second childhood.* What then *is* the ideal object of hygiene? We would suggest *a correct ballancing of the structure and functions of the body*, such as may tend to the prevention of *untimely* disease—which is merely another name for untimely *decay* of some of its parts. To express the problem mechanically an *equalization of forces and materials.*

The *means* of securing this correct balance between structure and functionary be classed under two heads, namely:

1. Normal extrinsic conditions or the surroundings of the individual and the community.

2. Normal intrinsic conditions or the personal constitution and conduct of the individual.

Under the first head, the surroundings, are classed: The *air*, the *soil*, the habitations, clothing and the water and food supplies.

Under the second class, the vast aggregate of influences comprised under the term personal habits·

As regards the first group the air we breate in Cincinnati, or rather the smoke it contains, has been the subject of much discussion from an æsthetic and a politico-economic standpoint, as it lessens the desirability of the city as a residence and renders it less qualified for the euphonious title of "Paris of America." That the question of smoke consumption or prevention is an important one hygienically, can hardly be doubted. Even if it be established that smoke is not a common direct cause of lung disease, it can hardly be claimed that it is a desirable ingredient of air for breathing purposes. This, therefore, may well be a subject for earnest consideration by this society.

With respect to our second item, the *soil*, we cannot change if we would; but we have done much to prevent its surcharge with excrementitious matters, by sewerage, and there is no doubt that the old-fashioned vault system should be entirely abolished in favor of more modern and sanitary methods. We may remark in passing, however, that the gravelly and sandy nature of the soil of the greater part of the city proper, as well as its favorable topography for natural drainage, are exceedingly favorable from an hygienic standpoint—decidedly more so than the stratified limestone and clay subsoil of most of our suburbs.

Closely connected with the subject of natural soil is the one of paving materials and pavements, and there could hardly be a more fitting time than the present for its consideration in the city. The hygienic pavement should be constructed with an especial view to surface. Cleanliness and non-absorption of organic materials in solution, which are likely, in process of decay, to give rise to deleterious gases to contaminate the atmosphere.

The question of habitations is so vast that anything more than a reference to it is prohibited by the limits of this report.

For the population generally the question must remain largely one of individual taste and preference. To what extent the sanitary authorities should have control or supervision of over-crowded, badly drained and otherwise anti-hygienic dwellings, which may become breeding places for the causes of disease, is a question for thought and suggestion. It is obvious also that the artificial drainage needs of a clay or limestone subsoil are far more urgent than those of a gravelly or sandy foundation.

Food, including drink, is of the utmost importance in an hygienic sense, and has been the subject consequently of numerous legislative enactments, ancient and modern, secular and religious. Laws regarding adulterteration of foods and drinks, are said to be very stringent in Great Britain, but perhaps not as effectively enforced as would be desirable.

Little or nothing has been done in this country to prevent adulterations of this class, and we still take our flour, spices, teas, coffees, sugars, syrups, candies, and baking powders, etc., on faith; not to mention alcoholic liquors of all kinds.

The adulteration of milk, however, has been, very properly, the subject of municipal legislation in our larger cities, and would appear of sufficient importance to warrant legislative action, in the interests of the rising generation. The cleanliness of the surroundings of the dairy and the freedom of its stock from tubercular and other diseases are really of far more practical importance than the mere adulteration of the milk with water; hence the need which exists for thorough dairy inspection.

An article of food that has recently been the subject of legislation by our general government, is *artificial butter.* This legislation, however meritorious or otherwise, has a very imperfect bearing on the hygienic aspects of the matter, since it imposes a tax for the main benefit of the producer of real butter—in other words the actual consumer receives no protection whatever, unless he be also the actual buyer in certain quantities. This leaves unprotected the large proportion of consumers living in hotels, boarding houses, restaurants, etc. From a strictly hygienic standpoint the matters of cleanliness, freedom from parasites and digestibility of artificial butter, well merit scientific investigation.

We frequently hear of what has been styled "the conflict between science and religion," but of far more practical importance is the conflict between science and politics. As regards some of the difficulties of enforcing hygienic enactments, reference may be made to a pamphlet by Dr. A. P. Stewart,* formerly of the Middlesex Hospital, England. Here we find that "when Dr. Robinson was appointed Officer of Health for Leeds, he found that he had to grapple with unparalled privy abominations, piggeries by the hundreds, numerous slaughter houses, the gigantic smoke nuisances, and an average death-rate of 30 in 1000. The battle between science and filth was prolonged and terrific, and the piggeries were made the battlefield. The pig owners taking alarm at Dr. Robinson's energy, formed themselves into a "Pig Protection Society," summoned ward-meetings, and commenced an active canvass for the purpose of turning out of council all who would not pledge themselves to vote for Dr. Robinson's dismissal. The case after being twice heard before the magistrates, who declared that the pigs were a nuisance and must be removed, was finally settled on appeal by the recorder who gave an order, *not* for the eviction of the pigs, but for the *daily removal of the manure,* for the due enforcement of which a separate inspector would be required for every pig sty!!"

Dr. Stewart's comment thereon is: "Under these conditions is a medical officer of health fairly encouraged to discharge his proper duties?" We in this country therefore may have at least the grim satisfaction of knowing that we are not alone in the enjoyment of the blessings which flow from what has been termed "practical politics."

---

* "The Medical and Legal Aspects of Sanitary Reform, 1867.

To the vast aggregation of anti-hygienic influences included in our second group, namely: personal habits,—social, moral and intellectual errors—the perverted instincts, appetites and passions, it is only allowable to refer here. Each one of them is a study in itself. Little doubt exists that most, if not all of these, are the outcome of the first group of anti-hygienic influences, viz.: the surroundings, vitiated air, improper clothing, poor quality or insufficient variety of food, exhausting and pernicious occupations, etc., hence their prevalence in cities and comparative rarity in well-to-do rural communities. With respect to personal habits, however, attention may be drawn to a generalization of Reginald Southey.* "Individual health is obtained by self-denial; habits imply self-indulgence." While this may be considered by some as rather sweeping and subject to modification in some respect, yet as the experience of a general truth it is well worthy of consideration.

Next in importance to the primary prevention of disease is the *limitation of its spread*, by the now generally accepted method of isolation, disinfection and general sanitary supervision. Here the acceptance of the Bacterial theory of infectious disease has led to the most important results in a hygienic, if not in a therapeutic sense. It is unquestionable that efforts in this direction would be much more effective than at present, were sanitary officials less trammelled by legal and political complications.

In conclusion your committee would respectfully suggest that the importance of the subject would perhaps warrant the annual appointment of a standing committee on hygiene, and that members be requested to report to said committee abstracts of their observations of such cases of disease as are more directly traceable to anti-hygienic influences. Personal observations regarding local needs for sanitary reform might also be referred for consideration to such a committee.

---

*Quain, Dict. Med.—art. Personal Health.

SHOULD LANDLORDS BE COMPELLED TO KEEP THEIR HOUSES IN GOOD SANITARY CONDITION?

By J. C. McMechan, M.D., Cincinnati, O.

On October 18th, 1885, I was called to see Mrs. S——, who had typhoid fever. All the symptoms of the disease were well marked, and she had been sick several days before I was called. She continued sick until Nov. 18th, when the fever entirely ceased.

On Nov. 23rd I was called to see her husband, whom I found suffering with the same disease. His fever was not so severe as his wife's, and only lasted twenty-one days.

About the time of his recovery his child, a boy of nine months, became very fretful, had diarrhœa, and seemed quite sick. As the child was teething, it was supposed that dentition was the cause of his sickness, and something was prescribed to relieve his apin. Instead of improving he grew worse, and upon taking his temperature it was found to be 105°. This high fever continued for several days, notwithstanding the administration of quinine and of sponging the patient every three hours with cold water. The fever, however, began to fall in the course of a week and the child gradually improved. The fever, however, lasted twenty-one days and proved to be a genuine case of typhoid fever.

About this time the nurse who had waited on these three patients was taken with the same fever, and went to St. Mary's Hospital for treatment. She had a very severe attack, and it was about three months before she was able to leave the hospital.

At that time it was difficult to tell the exact cause of the fever as the house in which the patients lived seemed to be in a good sanitary condition. The privy was out in the yard and some distance from the house. There was no water-closet in the building whatever, and the family used no cistern water. Notwithstanding the apparently good sanitary condition of the house, I advised this family to move out, but they were so comfortably situated they did not like to move, and concluded to remain.

All the members of the family remained well until about September 26th, 1886, when the little boy, who had suffered from the attack of typhoid fever, was taken with diphtheritic croup. He had not been out of the house for several weeks before the attack began, and upon careful inquiry it was learned that the disease must have originated at home.

Remembering the terrible experience of the same family with typhoid fever, I came to the conclusion that the diphtheritic croup must have originated from sewer gas.

One day, whilst attending the child with diphtheria, I entered the hall of the house, and as it was raining the windows had all been closed. It was a damp, sultry day, and upon entering the house the odor of sewer gas was very perceptible. The smell was so strong that I at once opened a window to let in fresh air. Several times, upon entering the house, I noticed this same disagreeable odor.

In the hall, in the second story of the building in which these people lived, was a sink into which all kinds of slop water was emptied. The waste pipe from this sink was small, and was undoubtedly filled with all kinds of debris, and more than likely at some time feces had been emptied into this sink.

The child died of diphtheritic croup, and yet the father and mother still live in the same building, notwithstanding they have been advised so often to move away, and notwithstanding the amount of sickness they have suffered in the building.

The landlord, however, upon my advice, had the small drainage pipe leading from the sink to the yard removed and a larger one put in its place; since then the odor of sewer gas has disappeared.

Now, a question arisis, Can a landlord be held responsible and be made to pay damages for keeping his house in an unsanitary condition?

This question has been answered recently in the Superior Court of our city in the negative.

A landlord can not be held responsible!

A few weeks ago I was called as witness to testify in the case of Schmidt *vs.* Abert.

In this case, Abert had leased a house from Schmidt for a year. Abert moved into the house, and had not been there more than two weeks until the family began ailing. They remained in the house five months, and during this time suffered from dysentery and diphtheria. Several members of the family had diphtheria and came near dying from the disease. They were so much reduced in health that a trip south was deemed necessary to recruit their health.

It was proven that the house was in a very bad sanitary condition. The privy vault was directly under the house, and the water-closet was immediately adjoining the kitchen. There was no window to the water-closet to let in fresh air, and the only escape for sewer gas was through a pipe six inches in diameter, which led up to the roof of the building, which was three stories high. The odor of sewer gas was quite perceptible in the house.

After the family began getting sick, the landlord was informed of the bad sanitary condition of the house. Upon examination, the privy was found filled. This was thoroughly cleaned and filled up with ashes. The water-closet was then connected with the sewer; but notwithstanding these measures the sickness continued.

It was supposed the first case of diphtheria originated from the sewer gas, as no member of the family had been exposed to the disease, and as they were all grown up they were not as liable to take the disease as children. The diphtheria continued after the house was placed in a good sanitary condition owing to its being a contagious disease.

At the end of five months Abert moved out. He paid the rent for the five months he occupied the house, but refused to pay for the whole year as he had agreed to do according to the lease.

Schmidt sued him for the remaining seven months' rent, and although his family had suffered so much from sickness while in the house, yet the Court decided he would have to pay the rent for the whole year.

According to the Judge's charge to the jury, the laws on this subject were all made for the protection of landlords and none for the protection of tenants.

There should be a law to compel landlords to keep their houses in good sanitary condition, and in case that a disease like typhoid occurs, a competent plumber should be sent to examine it, and if anything is found found wrong with the drainage it should be remedied at once. In fact, it ought to be the law that where a physician suspects anything to be wrong with the sanitary condition of a house he ought to be compelled to report this fact to the Health Officer, and he in his official capacity ought to have the power to send a competent person to examine the house, and in case he finds anything wrong, to compel the owner to have it fixed.

EDITORIAL.

A. B. THRASHER, M.A., M.D., Editor.

CONTEMPT OF COURT.

Dr. F. H. Darby, of Morrow, O., was recently called at Lebanon, O., to testify in behalf of the prosecution in what is known as the "Green murder case." The Doctor testified as to all matters of fact; but when called on to answer a question as to the usual results of such injuries, he declined to answer unless given an expert's fee of $25. Judge O'Neill decided that he must answer the question, rather than do which Dr. Darby suffered himself to be sent to jail. In a few days the Doctor was released on his own recognizance and charges were filed against him in the Court of Common Pleas.

Judge O'Neill refused to grant the expert's fee because, he claimed, there was no law for it.

The question of expert fee is one in which every physician is interested. Has the Court the right to demand something for nothing? To the consulting physician his opinion is his stock in trade, and it is for his opinion, and that only, that he demands and gets a consultant's fee. Just as a horse-shoer makes his living by shoeing horses, or the bricklayer by laying brick, so does a consulting physician make his living by giving his opinion. Would the Court ask a horse-shoer to shoe a horse and furnish all the material for seventy-five cents? Or a bricklayer to do twenty-five dollars' worth of work at his trade for a small witness fee? But it may be said that Dr. Darby was not a consulting doctor. In this country every doctor is or may become a consulting physician, and when he is placed on the witness stand and a question is asked him requiring in the answer skilled or scientific professional knowledge, then that doctor becomes a consultant in the highest sense of the word.

Professional evidence, except of the highest order, should not be allowed to go to the jury. The question is frequently one of life or death, of guilt or innocence, and no trifling with seventy-five cent opinions should be allowed. The poorest criminal in the state has a lawyer appointed to defend him, and the lawyer often gets a good, round fee from the public treasury. Doctors are as a rule too eager to give service at a low rate, and this failing is taken advantage of to place so-called expert testimony before the jury at a trifling cost.

We certainly think that our profession at large owes a debt of gratitude to Dr. Darby for thus boldly meeting this evil, and we know there is no doctor, worthy of the name, who will not wish him success. We trust that the profession at large will assist him in making this a test case, and thus establish a precedent which will inure to the benefit of us all.

MISCELLANEOUS.

SYPHILIS FROM VACCINATION.

The following report (*N. Y. Medical Record*) shows that vaccination should be performed only by a competent physician:

Dr. J. S. Prettyman, Jr. of Milford, Del., reports the following case: "Mr. N. T——, aged thirty, has been married nine years. His wife is healthy, has never aborted, and is entirely free from skin disease. They have two robust children, aged six and eight, who have always been well but are subject to a "breaking out.' Ten years ago the patient vaccinated himself directly from the arm of another, who, it was said, had been cured of a 'bad disorder.' In about two weeks an eruption appeared over the entire body and continued three months, appearing and disappearing several times since. From time to time lumps have been noticed over various parts of the body. He has never had ulcers in the throat, but the glands have been enlarged, and several times chronic abscesses have formed. He received no treatment except such remedies as he would apply locally. He came to my office Oct. 13th, with nodes, bullous syphiloderm, and ulcerations upon the neck, arms, back and legs. He denied all possibility of contagion from any other source, and affirmed that previous to the eruption he had not even once indulged in sexual intercourse."

INTRAPULMONARY INJECTIONS. — At the meeting of the Manchester Medical Society on Nov. 3, 1886, Dr. A. Ransome gave the details of one case of gangrene of the lung and four of phthisis, in which iodoform dissolved in ether, in olive oil, or in oil of eucalyptus had been employed, the latter vehicle being preferred. The case of gangrene of the lungs was restored to health, the treatment having been thoroughly carried out. In the phthisical cases only from two to eight injections had been used in each case, and temporary benefit was obtained in two of them. In one of the others symptoms of iodoform poisoning had followed an injection and in the remaining case temporary pneumothorax was produced. Hemorrhage from the lung followed one of the injections, in the case of gangrene, but without any bad results.

DISINFECTANTS.—Dr. John L. Davis, Lecturer on Materia Medica and Therapeutics in the Medical College of the University of Southern California, in an article entitled "The Life and Destruction of Micro-Organisms," (*Southern California Practitioner*, October, 1886,) says that "for purposes of disinfection and the destruction of micro-organisms outside of the body, extremes of temperature, especially heat, constitute our most valuable means." He further remarks that moist heat, as in boiling water or steam, is much more efficacious than dry heat; and that by five minutes exposure to a temperature of 212° in steam or boiling water most infective materials may be destroyed.

WRITERS' CRAMP.—Dr. Frank Woodbury, in an article on *scriveners' palsy* (*The Annals of Hygiene*), recommends as a preventive the use of a pen-holder made of some light, non-conducting material, as of rubber or cork, and that it be of ample size so that it can be easily grasped. Also the writing should be done by the movement of the arm and forearm, and not of the fingers. The very best preventive, he says, is the modern type-writing machine especially with those people who have to both write and think at the same time.

DRINK FOR DIABETICS.—Duchenne gives of a phosphate of potash solution (2 to 75 of water), a teaspoonful two or three times daily in wine or hop tea.—*Medical News.*

MALE AND FEMALE MORTALITY IN THE UNITED STATES.—In the first ten years of life male mortality is the greater. From ten to forty it is less than that among females, from forty to eighty-five it is greater again, and after eighty-five it becomes less. In

England the only period of life when the female mortality is greater is between ten and thirty-five. England is apparently a relatively healthier country for women than the United States.—*N. Y. Medical Record.*

◆

BOOK REVIEWS.

PRINCIPLES OF GENERAL PHARMACY, with special reference to Systems of Weights and Measures, Specific Gravity and its Uses, Pharmaceutical Manipulations. Pursuant to a Course of Adolphus Fennel, Professor of Practical and Analytical Chemistry, Theoretical and Practical Pharmacy, in the Cincinnati College of Pharmacy. Compiled by Charles T. P. Fennel, Ph. G., Professor of Practical Pharmacy and Instructor in the Pharmaceutical Laboratory in the Cincinnati College of Pharmacy. 8vo., 124 pp. Cincinnati: McDonald & Eick. 1886.

Says the Editor in his preface: "The design of these 'Lectures' is to present to the student of Pharmacy a course of instruction on weights and measures, specific gravity and its uses, and all the operations occurring in pharmaceutical practice, in the most simple manner. These lectures are based upon a course adopted by the late Professor A. Fennel when occupying the chair of Pharmacy in the Cincinnati College of Pharmacy."

There are many things in these lectures of great value to the physician; and, indeed, the general practitioner in the country must be his own pharmacist to a greater or less extent.

Prof. A. Fennel was by all means the most learned and popular of the College of Pharmacy Faculty, and his course of lectures will be welcomed by his many students scattered throughout the West.

The lectures have lost nothing at the hands of the brilliant young pharmacist, Professor Charles T. P. Fennel, and he is certainly to be congratulated on his happy style and the very good classification.

◆

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, January, 1887. No. 4.

DENTAL DEPARTMENT.

THE ROLE THAT DENTITION PLAYS IN INFANTILE PATHOLOGY.

Translation from *Le Progres Dentaire*, of November, 1886,

By G. S. Junkerman, M.D., D.D.S.

The Revue on the subject of diseases of childhood publishes a very remarkable memoir from the pen of Dr. Sèjournet. This memoir was crowned by the Academy at Paris. In it the author without attributing to dentition as much influence as some physicians claim for it, acknowledges that it plays in infantile pathology a rôle which is complex, variable, depending upon the subject, upon the age constitution, hygiene and heredity.

Convulsions, for example: Dr. Sèjournet shows by a number of examples, that they occur less frequently during dentition among children who have been nourished from the mother's breast than in those who have been raised by the bottle or have been too early fed.

In the *same family* he has observed that those of the children who were raised at the breast never suffered any during dentition, while those of the children who were raised otherwise presented grave symptoms.

The pictures drawn by Dr. Sèjournet from numerous cases showed also that heredity plays an important rôle in the etiology of convulsions of dental origin, and that those children whose parents had had some nervous disorder were particularly predisposed to this pathological condition.

There are the gastro-intestinal troubles, improper alimentation, which play also the rôle of predisposing cause. Finally the pulmonary symptoms, as congestion or catarrh, if they are not directly produced by dentition, will more easily come on at this period under the influence of the slightest cold.

It seems that dentition, although not a morbid phenomenon in itself, brings about notwithstanding, a certain influence upon the child and the condition of its health, at least upon its nutrition in general.

Apropos of this, Dr. Séjournet points out the symptom of milky urine which he has noticed in at least three-fourths of the cases examined by him. This is encountered, it is true, in simple gastric disturbances, but it happens so frequently in dentition that the mothers themselves know of it and look upon it as a physiological act when they see their children *pisse tout blanc.* It occurs here as febrile urine, without any other peculiarity than its coloration.

So when a child arrived at the age of first dentititon becomes sick and presents symptoms grave enough to change the nature of the malady, it is well to examine the urine and note the color of it, for the milky color of it is an argument in favor of trouble of dental origin.

It is well to know these things, for that which is prognostic of dentition one cannot consider as serious. for the symptoms which it produces never travel in the train of death. — (*Journal de Medecine et de Chir. Pratiques.*)

◆

A SIMPLE AMALGAM CARRIER.—Remote and nearly inaccessible cavities are often difficult to fill with amalgam. To carry the pieces conveniently, partly saturate a pellet of cotton with thick sandarac varnish, touch a piece of amalgam with it and carry it into the cavity, pressing it in lightly. Wipe off the surface with alcohol and condense with a pellet of cotton and so proceed. Dr. Herbst uses cotton to press a mass of gold into a large cavity. Cotton serves an admirable purpose used in the same way with amalgam.

A CRITICISM OF THE HERBST METHOD OF FILLING TEETH.

By Dr. W. W. Allport, Chicago, Ill.

Read before the Ohio State Dental Society, Toledo, October, 1886.

It will be remembered that when Dr. Herbst's method of filling teeth was brought before the American Dental Association, a little over two years ago, I then stated that, while not doubting that gold could, under certain conditions, be well packed into a cavity in a tooth by it, I was of the opinion that the objections to the system were so many and important that its general adoption in practice was neither practicable nor desirable. The opinion expressed was not received with much favor at the time, nor is it certain that many will agree with me now.

Thinking it possible that there might be good reason for changing this opinion in regard to the matter, I was glad when it was announced that Dr. Herbst was coming to this country to demonstrate his method, and subsequently that arrangements had been made for his presence at the late meeting of the American Dental Association, that we might see him operate and learn from him directly, the reasons for, and the particular advantages of his method.

The acquaintance I made with Dr. Herbst was certainly a most agreeable one. For him personally I have the kindest feelings, while for his genius I have a great admiration; and my respect for his head and his heart is such that I do not believe he would desire you or me to adopt his system of practice or commend it to others unless it had the approval of our judgment.

That gold can be well condensed by his system I have not a particle of doubt, nor have I ever had. Neither have I any doubt that the most excellent fillings may be made with crystal or plastic gold, for I have put in hundreds and I may say thousands of them. To be frank in regard to this matter, I will say that much of the little early reputation I may have gained as an operator was acquired in the use of plastic gold, for during the first few years of my practice in Chicago I seldom filled a tooth without using more or less of it, this being before the introduction of cohesive foil. But because good operations have been made with it and can be made with it is not a sufficient reason for its general use in practice, for experience and observation have taught that quite as good operations can be made with less exactness in details and labor, than is required in the use of this preparation of gold.

With a full acknowledgment of the possibilities that may be attained with this form of gold, the exactness and labor required to reach the highest results in its use are so great that it was long ago abandoned by a large majority of our best practitioners, though some still make quite extensive use of it, and all might possibly make a limited use of it to their advantage. Its general use, however, is neither practicable nor desirable, because quite as good results can be reached with foil with much less time and labor.

I make this reference to the use of crystal gold for the purpose of illustrating and enforcing my ideas in regard to what is known as the Herbst method.

Without attempting to discuss or explain the physics involved in the impaction of gold by revolving pluggers (burnishers), accepting the proposition as a demonstrated fact, I will, with your permission, state some of the objections which seem to me, must ever hold against its general adoption in practice.

The first I will mention is the great difficulty and sometimes impossibility of reaching all parts of the cavity with the straight and clumsy instruments which must be used by this method, — cavities which could be readily reached and the filling material properly packed with the variously shaped hand- or mallet-pressure instruments to be found in all well equipped operating cases. In many fissures or deep under cuts that could be readily filled by the old method, a doubt must always be present in the mind of the operator as to whether by this new method such places are perfectly filled or not, for Dr. Herbst himself admits that the only way he can be certain in this matter is to test the questionable places with small hand-plugger points. It requires no argument to show that a plugger which cannot be relied upon to make known a defective place in a filling cannot with certainty be relied upon to make the filling good at that point, for an instrument which is too clumsy or ill adapted to find the defect with is certainly not well adapted to properly fill it with, when found. If hand or mallet pluggers can be more safely relied upon to find and fill difficult accessible points about a filling, than can the Herbst method and pluggers, their superiority for filling the balance of the cavity, or for making simple fillings in easily accessible places can hardly be justified.

Second. To make this method available, we are instructed to cut away as much of the sound and strong portions of the tissue as will make all portions of cavities accessible to these arbitrary and clumsy instruments. To this procedure I object and enter an uncompromising protest, for no one has a right to use an instrument or adopt a practice which makes it necessary to sacrifice sound, healthy tooth structure, that could be saved by the use of other materials, instruments or methods of practice.

In preparing a cavity to receive a filling it is the duty of the dentist to remove all tooth structure that cannot be saved in a healthy and useful condition, but no more. He has the right to cut away as much of the sound structure of a tooth as may be necessary to secure a firm foundation and retention of his filling. But in doing this it is his duty to see to it that the material used for his filling is, of its kind, the most easily adapted to the intricacies of the cavity to be filled: also that the instruments used in packing it are such as are the best calculated to reach all places in the cavity rendered difficult of access, by virtue of saving portions of the tooth, the removal of which would necessarily and forever mar its beauty and harmony. To remove more than this to suit his own convenience, or to use any particular materials or instruments in filling, might, without a very great stretch of imagination, or injustice, be considered malpractice, in a mild form at least.

While these remarks are made with special reference to the unnecessary sacrifice of tooth substance by adopting the Herbst method, I will say parenthetically, that they are not without quite too frequent application in regard to fillings put in with cohesive foil. Teeth that could be just as safely filled and much more of the tooth structure saved by a judicious and skillful use of non-cohesive combined with cohesive foil, are in part, mercilessly destroyed in order that the successful use of cohesive foil exclusively may be insured.

Admitting, therefore, that, under certain circumstances, good fillings may be made by the Herbst method, but to do which, in other cases, would require the destruction of more tooth structure than would be necessary in making good fillings by other well known methods, I believe its general adoption in practice is neither desirable nor justifiable.

Third. As "time is often said to be the essence of a contract" an important factor in the consideration—so too, the time consumed in the use of any particular tools or instruments, in doing a given thing, when contrasted with the time consumed in producing just as good results with other materials and instruments, is an important factor in wisely choosing the instruments and materials to be used.

In making these remarks I am aware that the claim is made by some that much time can be saved by this method; this I do not believe to be true. The same claim was made for crystal gold when it was first introduced, and later for plastic gold when it came up for our approval. Good fillings, we were told, could with old burs or most any kind of an instrument, be put in with it in from two to three minutes. In neither case however, has experience proven the claim to have been well founded; on the contrary more time is consumed in putting in good filling with either of these materials than is required with foil. The same history is to repeat itself in regard to the Herbst method. No doubt fillings can be put in by this process very quickly, but the highest results from it will only be reached by it after much painstaking labor.

If, therefore, as I believe is the fact, under favorable circumstances more time is consumed in making good operations by the Herbst method than by those just mentioned, the method is neither practicable nor desirable in this practical and time saving age, for time is money, not only to the dentist, but also to the patient.

Personally I have had but little experience with these rotary pluggers, but I have seen Dr. Herbst and my friend, Dr. Rehwinkel, operate, and I have witnessed some of Dr. Marshall's experimental operations by this method, and I confidently assert that I have seen better fillings made by hand mallet, and the old fashioned hand pressure method, and that too, in much less time than was consumed in making the fillings by the Herbst method. My observation has thus far led me to the belief that there is no saving of time or superiority of operation to be obtained by the new method over the old system. Therefore, as a matter of economy, or superiority of results, I see nothing to justify its general adoption.

Fourth. That quite as good or even better operations can be made under circumstances favorable for the Herbst method, by the use of suitable instrnments and non-cohesive foil enameled with cohesive foil, under mallet pressure, and without the necessity of sacrificing so much sound tooth structure.

While the objections to this method as a general system of filling teeth are so obvious that its adoption is not warranted, it is possible that as an adjunct to other methods of practice it may be made useful; in fact, I believe it can be. From what I have seen I think it can be made useful at the cervical walls of cavities, espeially when the matrix is used. The surface of the pluggers being smooth, and the impact made without violent concussion; when proper access can be had it should be advantageously used in packing gold against the margins of cavities, preventing the fracturing of the enamel which so frequently occurs in the use of the mallet pluggers. No doubt it may be advantageously used in other places, but those mentioned are where its greatest excellence will be found. Could a wise judgment be exercised in determining when and where it could or could not be used with benefit, I have no doubt that it might with advantage be occasionally employed. The fear, however, is that an over zealous advocacy of the system by its friends will lead many to use it when better results could be secured by the old methods. By its general adoption or too frequent use, frequent failure would be the result, and the method brought into undeserved disrepute, with its abandonment, even while it could be used to advantage, thereby losing, in a measure, at least, the benefits that might follow from a judicious advocacy and use of it.

Now, Mr. President, having stated to you freely and frankly some of my objections to this method of practice, I trust that no one will think I had have the least intention of being unkind or harsh to any one, for nothing could be farther from my desire. I have only intended by words of truth and soberness to make my views clear to you—to be approved or disapproved, by argument or the test of time, as truth may justify.

For Dr. Herbst I have a great admiration. He is more than a Yankee in invention, as generous as King Lear in giving; nor is he so conceited that he cannot learn from others; he freely gives and is wise enough to freely receive. As a profession we are under many obligations to him for the many useful inventions and "tricks," if you please, that he has left with us, and we shall gladly welcome his promised return to this country next year.

THE LITTLE PULP'S TRIUMPH.

I.

An irascible pulp which had long been complaining,
Spake thus to itself: "What's the use of refraining?
Creasote, oil of cloves, turpentine, paregoric,
Make a compound of smells that would sicken poor Yorick.
I'll no longer submit to such flagrant abuse,
But I'll hump up my back and just ache like the deuce."

II.

With a thrill and a jerk and a quiver spasmodic,
The disturbance commenced; while pangs, periodic,
Through *chorda-tympani et supra-maxillæ*,
Through *tempora-facial per viam axillæ*,*
Bore tidings of outbreaking wrath and rebellion,
And roused up the legions of pain by the million.

III.

Said the man to his wife: "I could bear without flinching,
The rack or the screw— I could tolerate lynching;
Could sit like a Spartan and watch the keen blade
Sever muscle and tendon; could stand undismayed
While you seared me with cauteries, flayed me with thongs,
Or pinched me with inquisitorial tongs.—"

IV.

"But the toothache, of all dread inflictions refined,
Is a thing *sui generis*—(of its own kind),
It wears out your patience, exhausts your good-nature,
Pursues you like some diabolical creature:
It does n't hurt much all at once, but it harries,
And worries and frets you as long as it tarries."

V.

On hearing this speech, the pulp gave a slight chuckle
And softly remarked, "now to business I'll buckle."

---

* New short-line route through anatomical fields.

Then pausing a moment to gather its forces,
And quietly summoning all its resources,
It gave a tremendous upheaval, and quivered
'Till all the arch-demons in hell seemed delivered.

VI.

"Great Jupiter Ammon! inanimate Cæsar!
Send quick for the doctor; this camphor won't ease 'er!
I'll have the confounded old thing out to-morrow;
I've found that delay is the father of sorrow.
Now make me a mustard draft; quick, heat some flannel.
Can't you open the door? here, I'll kick out a panel."

* * *

VII.

"Will it hurt very much, Doctor? I can endure it
Of course, if you're certain no treatment would cure it.
But this thought occurs to me; could n't we let 'er
Have one more short trial? Perhaps she'll get better.
Why, it's past nine o'clock, sure as I am a sinner.
I'll drop in again, on my way home to dinner."

F. W. S.

LONDON SNOBBISHNESS.—A curious story illustrating the snobbishness of London society is told in an English paper as follows:

There is in London an American dentist who is very skillful in his profession, and among other people has attended the Princess of Wales. He was invited to one of the annual garden parties at the Marlborough House, and met there nearly fifty of his patients. They cut him to a man. Soon after he found himself face to face with the Prince and Princess, and they at once gave him the most cordial reception and shook him warmly by the hand. At once every one of the fifty patients pressed up to the lucky dentist and shook hands with equal warmth.

LOOK OUT BOYS!—A young lady dentist is reported as having quietly purchased a "cow-hide" upon hearing that a young dude patient had circulated a story that she relied chiefly upon "hand-pressure."

MISCELLANY.

IS THIS SOUND DOCTRINE?

Excesses of any kind of food are greatly detrimental to the mental and physical welfare of the child. But when those excesses are of certain classes of food which are absolutely indigestible and which are given to the exclusion of proper food, the matter becomes almost criminal. Thus in cases of children under three years of age, potatoes are absolutely destructive to the healthy condition of the child. One of the reasons for this fact is that the liver of a child is much larger in proportion to its size than a grown person's liver, and it has not the capacity of digesting the starch. It is asserted that a child who is fed on potatoes in excess never can have good teeth, there being no change from starch into bone or ivory, while the child fed on nuts or soups, oat meal or corn meal, has always good teeth.—*Exchange.*

[Researches made in all countries and climes have failed to establish the hypothesis that food alone has any very marked influence upon the character of the teeth. The Italian's diet of macaroni; the Irishman's diet of potatoes, and the Esquimaux's diet of blubber afford no striking example of the influence of food for either good or bad upon the teeth. The Scotchman's partiality for oat-meal, it has been remarked, is accompanied by an exceptionally fine quality of teeth among that people, but the opinion of careful investigators attributes that fact largely to other hygienic considerations referring to general habits of life.—ED.]

DR. HERBST'S METHOD WITH GOLD AND AMALGAM COMBINED.—Dr. Herbst lines cavities with gold for filling with amalgam in the following manner: A large cylinder of Wolrab's gold is compressed between the fingers and dipped into a very thin solution of gum-copal in sulphuric ether, which is used for the purpose of preventing the mercury of the amalgam from uniting with the gold. When this compressed cylinder has been moistened with the liquid, the surplus is pressed out with the fingers, the ether allowed to evaporate, and then by means of a piece of cotton the gold is pressed against the labial wall of the cavity in the tooth to be filled with amalgam. The gold in this manner can be thoroughly condensed by means of a rotating burnisher in the engine, and will not alter the shape of the cavity. When ordinary round undercuts have been made, the amalgam will be held in position without any trouble. Dr. Herbst exhibited many teeth which had been filled in this way several months ago and showed no signs of discoloration, but presented the most natural appearance, although their labial walls were very thin, so much so that the gold was visible through the enamel.

SECONDARY DENTINE UNDER CAPPED PULPS.—Now comes the distinguished authority, Dr. G. V. Black, with the discouraging statement that indications of secondary dentine forming under a pulp capping are not at all to be regarded as marking a successful attempt to permanently save the pulp. Quite the contrary in fact. Dr. Black states that probably in a large majority of cases the final death of the pulp is sure to follow this sign within a period of ten years at the utmost. This is disheartening, especially so if we are to accept the seeming implication that the measure of success in capping pulps has been supposed to rest upon the dentist's ability to induce these formations. This is an open question, as we understand it. Many pulps have been purposely uncovered after having remained capped two or three years, and have exhibited all the sensitiveness originally observed, showing no disposition to a secondary deposit. But supposing that a majority of capped nerves are doomed to death from the cause mentioned (which we are aware Dr. Black does not state to be a fact), the question would arise: is it better to devitalize at once in such cases? Several considerations would be found adverse to such a course. First of all, the process of calcification expected would tend to effect a consolidation of the tubular structure and dental fibrils favorable to the preservation of tooth color, even should death of the pulps finally happen. In the instances of young patients, the change of color in a tooth, notwithstanding the removal of the devitaiized pulp, amounts often to a serious blemish. On the other hand, the later in life death of the pulp occurs (even though the putrescent pulp be not removed), the less the change in color. We have always advocated capping pulps in cases at all favorable; at the same time we have long suspected that the percentage of cases where the pulp remains alive and in its normal condition is small. No doubt many die without causing trouble. But even that result, though disappointing, is better than indiscriminate destruction, and if the death of a pulp is to be prognosticated from the known fact that secondary deposits are being made under a filling, why, we can only console ourselves by reflecting that the same thing often occurs spontaneously in teeth that have never decayed and required filling.—[ED.]

ENGINE MOTOR.—The Wheeler & Wilson Sewing Machine Co. exhibited at the last Cincinnati Exposition a coiled spring motor for running sewing machines. It was contained in a box about two feet high and eighteen inches square on the top. By the use of a crank, easily operated, the machine could be wound up in ten minutes to run two hours. We understand one or two were sold to dentists for running the engine.—[ED.]

OF VALUE TO OPERATORS.—To prevent blackening the finger-nails while working in the laboratory, paint the nails and the creases of the finger-joints with sandarac varnish. This prevents the dirt from penetrating. It may be sponged off with a little alcohol, bringing the black stain with it.

A NEW USE FOR ALLOYED FOILS.—It is a fact not generally known, perhaps, that alloys of any metal are stronger than the pure metals. This suggests the use of gold and platinum foil or gold and iridium foil (heavy) for "strapping in" fillings liable to be broken out by lateral pressure.

A PLAY ON WORDS.—A patient while waiting his turn in our office glanced through several dental journals and remarked that he found them very *toothsome* reading.

THE EMPRESS JOSEPHINE had badly decayed teeth. It is mentioned also that she was fond of soup. This appetite is easily accounted for by the dentist, when he considers that soup is "filling."

[The above joke recommends itself more on account of its fantastic originality than for any special lesson it teaches.—ED.]

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, February, 1887. No. 5.

MEDICAL DEPARTMENT.

THE MANAGEMENT OF CORNEAL DISEASES IN GENERAL AND IN PARTICULAR.

A Didactic Lecture delivered at the Medical College of Ohio

BY PROF. W. W. SEELY.

Reported by C. W. TANGEMANN, Assistant to the Chair of Ophthalmology.

GENTLEMEN:—To-day we will continue the consideration of diseases of the cornea. When we last met I called your attention to the symptomatology of this class of diseases, and to-day we will make some general remarks on the treatment and the principle underlying the management of this class of cases. The insult to the cornea, whether it comes from within or without, has little if any influence on the course of treatment as I have been carrying it out for several years past. To make a wound such as is made through the cornea when the operation for the removal of an opaque lens is made, does not act as an insult to the cornea, as is proved by the fact that in the course of twenty-four hours it has entirely healed. If for some reason it should not be healed then, it must be treated precisely the same as you would treat an ulcer or an abscess, no matter what the cause may have been.

The treatment of corneal diseases, as laid down in the majority of your text books (atropine and irritants), is of little or no value, the theory of application, to my mind, is certainly a faulty one, and since I have changed my mode of treatment to more rational plans, my results are fairly good, yes, beyond a doubt, better than under the old plan. Atropine was then and is now employed to quiet the pain and sensitiveness to light, in phlyctenular kerrtitis, but the patient usually went from bad to worse. The use of a mydratic in this connection (inflammations of the cornea) positively has only one indication, and that is when by complication the iris becomes involved; then the pupil must be kept dilated by means of a weak solution of atropia or duboisa in order to prevent adhesions. The so-called astringents to control the inflammation and injection of bloodvessels, act only as irritants. Eserine must be the fundamental remedy in *all* these cases, no matter what the cause. This does not follow alone from clinical experience, but also from logical reasoning. Eserine reduces intra-orbital tension, and is a typical astringent or contractor of bloodvessels, without the irritation and subsequent dilatation of bloodvessels which follows the astringents recommended by nearly all authors. It should be used in a solution of four grains to the ounce of water; a few drops instilled *once a day*. Should you find a case that does not tolerate eserine well, combine it with cocaine, or use the eserine first and in the course of a few minutes instill a few drops of a ten per cent. solution of cocaine.

Do not put a bandage in inflammation of the cornea, it only makes the patient uncomfortable and keeps the eye hot.

You will find that this will be all the local remedies that are needed in this connection.

What are the indications for constitutional remedies? Years ago already I came to the conclusion that the only remedy of any importance was quinine. What its physiological action is I cannot say. Undoubtedly many cases of corneal inflammation are caused by such poison as quinine will counteract, and these are as a rule the special cases where local applications do not seem to act well. Of late years we have found that the action of quinine cannot be attributed to the prevention of the migration of the white corpuscles, that is entirely too mysterious. Recently we have been using a remedy that is giving better results than quinine, viz: salicylate of soda, from one to two drachms in divided doses during twenty-four hours. Its action is undoubtedly the same as that of quinine. This agent is especially indicated where rheumatic symptoms arise, or where there is a tendency to rheumatism. It matters little about the theory, it remains a clinical fact that such cases as are obstinate and resist topical applications, are many times wonderfully benefited by these two last named remedies. Even though you do not remember much about corneal diseases, these few facts, so plainly put, are worth remembering.

In interstitial keratitis you are advised again by your textbooks that it is a condition due to syphilis, and antisyphilitic remedies are indicated. The fact is there never was a case of this kind benefitted by iodide of potash and mercury. The theory is a fallacy and has found its way into literature. Phlyctenular keratitis is almost entirely confined to childhood. Now whether the insult comes from within or without I am not prepared to say. The intense photophobia in these cases is often difficult to overcome. The suggestions of forcibly pulling the lids apart and exposing the cornea to light, ducking the head in a tub of water, splitting the outer commissure, etc., for the relief of this sensitiveness, are not practical. A few drops of a solution of cocaine, a few instillations of eserine, a full dose of quinine or by preference, salicylate of soda, will nearly always have the desired effect. Sulphate of calcium has a good effect in some of these cases, but we do not know its action nor *when* it is indicated in a given case. After eserine has been employed for a few days and the child opens its eyes, you may for the first time see the cornea and see it covered by one large or a number of small white spots or opacities. These are the result of the inflammatory process. In all the various corneal disturbances, eserine will serve you a twofold purpose, viz.: lessen intraocular tension and cut short the inflammatory process by its action on the bloodvessels.

◆

DISINFECTANTS DEFINED. — No little confusion exists in the popular mind as to what constitutes a disinfectant, a deodorant and an antiseptic. The American Public Health Association has defined these terms as follows: A disinfectant is an agent capable of destroying the infective power of infectous material. Agents which merely mask unpleasant odors are deodorants, and their purpose is not the destruction of disease germs. Antiseptics are agents having the power to arrest the process of putrefaction.

A CASE OF SYPHILITIC DISEASE OF THE NOSE.

BY J. A. THOMPSON, M.D., Cincinnati.

W. L.. æt. 30, came to me to be treated for what he called catarrh, about August 1st. He was a stone mason by trade and looked thin, pale and dejected instead of presenting the robust aspect of a laborer in the open air. He complained chiefly of an offensive purulent discharge from the right nostril. On examining the nasal cavity I found an extensive ulcer over the whole anterior upper half of the inferior turbinated body on the right side. This ulcer was covered with a thick scab or scale of exuded matter. Removing this, a profuse purulent discharge could be seen apparently escaping through the inflamed and ulcerated membrane. The left nostril showed nothing abnormal at any time. The patient admitted a specific infection nine years before, and his cachectic appearance, the enlarged lymphatics, and occasionel acne papules, showed the disease was still active.

He was given an alkaline wash to cleanse the nose. Internally ten grains of potassium iodide thrice daily were ordered and daily insufflations of iodoform were advised. But as his occupation kept him out of the city most of the time, I did not see him again for a week.

When he returned he had grown rapidly worse. The ulcer had extended and the whole anterior half of the inferior turbinated bone was undergoing molecular disintegration.

He complained of severe occipital pain and was extremely nervous. He had as marked muscular tremor as a victim of acute alcoholism. The necessity for more energetic treatment was so apparent that the dose of iodide was at once doubled, and he was also given bromide of potassium, grs. xx every three hours. I also required him to quit work and to come daily for insufflations of iodoform into the nostril. After three days the headache and tremors were greatly relieved and the bromide was discontinued. The iodine was continued for ten days with gradual improvement in his condition. At the end of this time the iodine eruption appeared, and coincidently with it a marked change for the better was apparent. He began to improve in flesh and strength and the nasal ulcer began to heal, with loss of the anterior half of the lower turbinated bone. The iodide was discontinued and tonics substituted and the patient resumed work. The insufflations of iodoform were continned whenever it was possible to see him.

For two weeks recovery was uninterrupted. The ulcer had healed at the end of this time until only a narrow strip of granulations remained. When he returned a week later a condyloma half an inch in length and almost as thick had grown from the site of the remaining ulcer. It was immediately removed and the base cauterized. He was again ordered the iodide thrice daily.

One week from the removal of the first condyloma a second, almost as large, had taken its place. This was also removed and the caustic again applied. The remaining ulcer healed without further trouble and I saw no more of my patient for more than a month.

When he came again to see me he brought wrapped in a paper the posterior half of the right inferior turbinated bone which he had blown from the nostril. Under the same local and constitutional treatment as before the ulcer is healing kindly.

This case is valuable as a confirmation of Sänger's view that ulceration of the Schneidcrian membrane is not necessarily antecedent to caries of the bone or cartilages. In the first attack from which the patient suffered, the appearance of the ulcerated surface and escape of pus from under the membrane left no doubt that the bony framework was the primary seat of disease. In the second attack the necrosed bone escaped from its enveloping membrane, leaving it almost intact.

439 John Street.

◆

"VOCALISTS' SOUP.—Take an ounce of sago and after washing it in boiling water add it gradually to a pint and a half of bouillon which should be hot. After half an hour's simmering it will be well dissolved. Beat up the yolk of an egg and add half a glass of boiling cream and stir them all into the soup not allowing the latter to boil lest the egg should curdle.—*Food Journal.*

CONGENITAL CYANOSIS—DEATH—POST MORTEM.

By E. S. McKEE, M.D., Cincinnati.

I was called to attend a woman in labor. The delivery was without note but the child showed marked evidences of cyanosis. This disappeared on the 2d day. On the third day a messenger called me in haste, saying, "the baby is queer; has convulsions and don't notice anything." The convulsions of course were over before I could get there. The child then had the thrush from which it recovered but seemed to suffer from an ill defined trouble. On the 14th day it lay perfectly still, most of the time on its right side. The cyanosis disappeared, especially in the fingers, toes and fips. Died on the 15th day.

Autopsy, 14 hours after death: Head somewhat enlarged, calvarium and meninges healthy. Both lateral ventricles were filled anteriorly with clear serum, posteriorly with puriform and softened brain matter. Each ventricle was distened one-fourth of an inch; third ventricle also distended, but the *iter a tertia ad quartum ventriculum* and 4th ventricles nearly normal. Choroid plexus and other parts nearly normal. On the under surface of the brain the piamater covering the pons, cerebellum and medulla was covered with flakes of lymph. No sign of tubercle could be found. Lungs normal.

Heart: No excess of fluid in the pericardium. Organ of normal size, but on examination the right auricle was found a little enlarged and the left auricle small internally but admitting the pulmonary veins. Internally the valves were all normal. The septum between the ventricles was incomplete in its upper part and lead into a common artery representing the aorta, closed by three normal semi lunar valves. The orices of the two coronary arteries lay behind the two anterior valves. Both ventricles normal. Foramen ovale normal but closing. The remains of the pulmonary arteries consisted in an upward prolongation from the right ventricle and a tube, which opened above into the aorta was separated from the infundibulum below by a membranous septum. The aorta passed upwards one-half inch and divided into two branches; the right, the larger going above the right bronchus having hooked beneath it the right recurrent laryngeal nerve to gain the right side of the vertebral column. The left passed above the left bronchus, curved downwards and became the descending aorta. From the right arch ascended the common carotid and the subclavian in the order named. That on the left gave off the innominate which in time gave off the common carotid and the subclavian. It then continued as a large artery corresponding with that on the right side but smaller in calibre, terminating behind and below the bifurcation of the trachea in two parts, each subdividing into numerous branches carrying the blood supply to each lung. No trace of the ductus arteriosus could be found. Other viscera normal. The mother of this child was markedly strumous, which is given as a cause of this malformation. She could recall no fright which could have been blamed with the causation of the trouble.

In the majority of cases where a post mortem examination is made the pulmonary artery is found to be either obliterated or greatly lessened in its calibre, and the septum ventriculi is absent in its upper part, allowing the two ventricles to open into one common artery. Clubbing of the fingers and toes is noticed, especially in those who have lived for some time. Dr. Norman Moore, pathologist to St. Bartholomew's Hospital, has made microscopical examination of these clubbed members and reported his findings to the Pathological Society of London. He finds it due to engorgement and slight thickening of the walls of the vessels. Females who live to maturity, and a few attain adult age, do not have the flow of the menses until late. The youngest on record is 16 years. One cyanotic woman is on record as having borne two children.

◆

ARSENIC WITH QUININE IN THE TREATMENT OF MALARIA.—Dr. Ernst Hensler, of West Franklin, Ind., warmly advocates combining arsenic and quinine in the treatment of malarial fevers. He says that his residence in the Ohio bottom lands has given him a wide experience in this class of diseases. Like so many other physicians, he formerly used either quinine or arsenic alone, and often without success; but latterly he has been in the habit of giving the two drugs at the same time. Since commencing this practice, he states, all his cases were rapidly cured and no relapse occurred.—*N. Y. Med. Record.*

A NEW PHYSICIAN'S OFFICE CABINET.

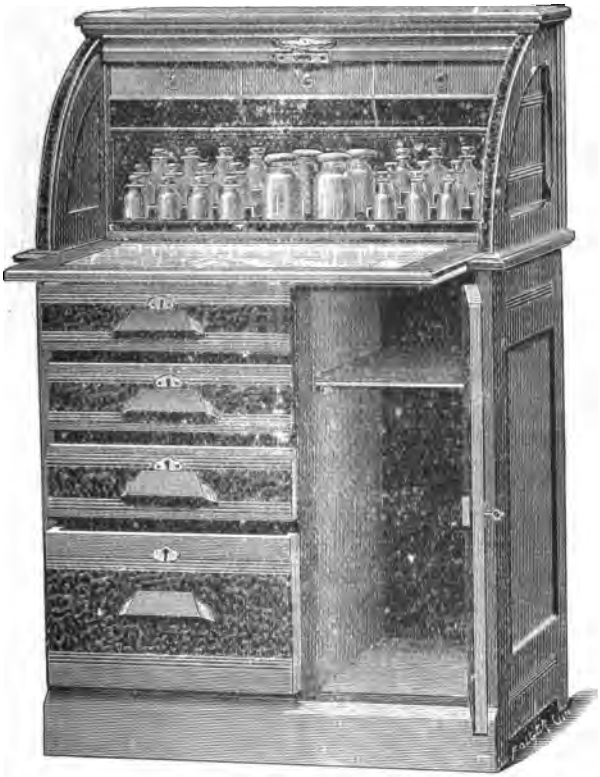
By W. H. WENNING, M.D., Gynecologist to St. Mary's Hospital.

Among the various cabinets for physicians' use there are none, which in all respects, answer the requirements of daily office practice. If intended solely as a receptacle for instruments, a second cabinet must be had for the preservation of medicines and agents for topical applications. Placing the latter in the same compartment with instruments is objectionable on account of the danger of spilling fluids which may come in contact with instruments and injure them. The use of two separate cabinets, on the other hand, is inconvenient and time-robbing.

To obviate these objections by having the medicinal agents and instruments together in one cabinet, and yet practically separated from each other, was the object in devising the physician's cabinet. It consists of two apartments—the upper for the use of medicines, the lower for instruments. When closed the cabinet in all respects resembles a lady's writing desk, and is an elegant piece of furniture, which may be placed in any room without betraying the use for which it is intended. Physicians who have no separate office or consultation room will find this a desirable feature. When the roll top is thrown back the inner arrangement of the upper compartment is at once brought to view. A dozen of one-ounce tincture and a dozen one-ounce salt-mouth bottles are arranged in three tiers (each containing four bottles), on each side in the open space, whilst the middle portion contains four jars. These tiers are provided with circular openings in which the bottles and also the jars fit closely, so that there is no danger of the latter being upset when the cabinet is moved. Each of these tiers, as well as the middle slide, may be drawn out so far that the last row of bottles or jars may be easily brought within reach.

(As the cabinet was originally intended for gynecological use the middle space is provided with jars. For Physicians in general practice, or such as dispense their own medicines, the jars may be omitted and a pair of scales—or if the bottles are intended for chemical reagents, as urinalysis-test-tubes etc., may be substituted.)

Just below these sliding terraces is another large slide covered by a slab of heavy plate glass. This slide practically divides the cabinet inlo the two compartments alluded to in the beginning of this article. Being of glass the slide may be used for placing instruments upon it when in use, or mixing powders, making pills, etc., and may be easily cleaned, for blood and corrosive medicines do not affect its surface. It may be drawn out about 8 inches. Above the bottles and jars are three small drawers and as many shelves for small articles, such as pencils, brushes, spoons, etc.



The lower half of the cabinet consists of four drawers for instruments, the lowest one being of extra large size to hold basins, bowls, etc., if desired, whilst the side closet may be utilized for stowing away large articles also, or may be filled up with shelves at the convenience of the physician.

The cabinet is 44 inches in height, 29 inches in width and 20 inches in depth, so that it occupies but little space in the room. It is provided with easily rolling, double castors, by means of which it may be readily rolled about in the room without danger of upsetting the contents.

Dr. Geo. E. Jones and the writer of this article, who have devised this cabinet together, have each had one in use for nearly six months and can safely recommend it as at once cleanly, compact, convenient and of elegant appearance.

They are made by Thomas Kelsall, the well-known manufacturer of elegant office furnitue, and for sale by M. A. Spencer & Co.

◆

ANTIPYRIN IN HEADACHES.—The headaches which accompany fevers are treated by Dr. John B. White (*Medical Record*) by giving one or more doses of 15 grains of antipyrin. He says: "In course of large experience with antipyrin, I have found that, when administered in masterful doses, it not only promptly relieves the symptoms of headache whenever present, whether resulting from disordered digestion, disturbance of the menstrual functions, loss of sleep, undue mental effort, or even that associated with dreaded uræmia, but also possesses reliable prophylactic virtues against recurrent attacks of cranial neuralgia. So confident am I of the power of this remedy to disappoint neuralgic headache, when imminent, that I have instructed many patients, who are liable to such visitations, to keep in readiness and take a dose of antipyrin as soon as they have premonition of its recurrence, and all so far testify in favor of its efficacy. The value of this remedy in the above respect has not been only tested in my hospital and private practice, but I also record the fact that it has proved successful in the hands of professional friends, upon whom I had urged its employment, for the relief of neuralgic affections of the head and face. I have been singularly impressed with the promptness of relief which often followed the administration of even a single dose of 15 grains of the autipyrin. The grateful relief from headache usually ensues within half an hour after the drug is taken. A sense of drowsiness ordinary supervenes, followed by a brief but sufficient slumber, and the patient awakens quite relieved of this distressing symptom. I have never yet seen the sleep-disposing properties of antipyrin alluded to by any other observer, although this effect seldom fails to ensue when a full dose, such as I have named, has been taken."

EDITORIAL.

A. B. THRASHER, M.A., M.D., Editor.

WHAT "KILLED" SENATOR LOGAN?

When an ordinary individual dies we are accustomed to say that he died of the disease named as the cause of death by the attending phycician, or, in exceptional cases, by the coroner. In Cincinnati, with a weekly mortality of 100, the cause of death given by the physician to the Health Office is never questioned. Cincinnati physicians can congratulate themselves on the high standing in which they are held by the general public. A like confidence does not pervade the East.

From the report of the attending physicians one might be led to believe that President Garfield died from injuries resulting from a gun-shot wound, penetrating the liver and entering the spinal column; but the most common report in the secular press was that he died from malpractice—the physicians, one version had it, meddling too much with the wound; according to another, the treatment was not sufficiently radical.

General Grant died, so said his physician, from epithelioma of tongue and throat; but newspaper report was divided as to whether too much or too little treatment had been instituted, but was pretty unanimous in circulating the opinion that, some how, he was "killed" by the doctors. The cases of General Hancock and General Arthur are repetitions of the above. But all the above distinguished gentlemen suffered from extraordinary lesions.

Now, however, comes General Logan with one of the most common of diseases. His army experience was just what would most likely give him the disease. His family history would point toward death from rheumatism. He had suffered from previous attacks.

The fatal illness came on him when he was laboring under very considerable mental worry. Under the circumstances, that cerebral symptons should soon supervene, was not at all wonderful. The attending physicians were alert to the danger and gave a grave prognosis as soon as the change appeared. Everything which is known to be of use under such conditions was promptly employed. Nothing was ventured as an experiment; no risk was taken, as the importance of the case was fully recognized.

The body of General Logan was hardly cold when the telegraph wires bore the message all over the country that he had been "killed" by the administration of an opiate. And this sage (?) opinion was formulated by a man ignorant both of the pathology of the disease and the theraphy of the drug.

No wonder physicians want large fees for attending famous men.

If all of these gentlemen had lived in Cincinnati as ordinary citizens, and had been treated for the same troubles in the same way, no one would have questioned the treatment or that they died of different causes assigned. Either Cincinnati physicians enjoy to an extraordinary degree the confidence of the public or our eastern brethren who have attended prominent men have cause to feel badly used.

The only "sure cure" we know for this trouble is for all physicians to refuse professional services to all eminent men. Then there would be no *causus morbi*; and these renowned mortals, would they become immortal?

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES.

1632 Chestnut Street, PHILADELPHIA, PA.,
Dec. 26th, 1886.

A. B. THRASHER, A.M., M.D.,
Editor of the Medical and Dental Journal:

DEAR DOCTOR:—The "Annual of the Uuiversal Medical Sciences," is a new publication having for its object to present at the end of each year, a report of the progress of every branch of medicine, during that year, in the different parts of the world. "Corresponding Editors" have been appointed in all countries with which postal communication exists, whose duties will consist in furnishing the editorial department, here, once or several times a year, an outline of all new facts relating to the branches of medicine assigned to them. This information, added to that obtained from journals, new publications and other sources, will be placed in the hands of "Associate Editors" chosen among the most eminent men of this country, who will write the final sections of the work, each being entrusted with a subject to which he has given special attention. In addition to procuring information npon the progress of general medical sciences among medical men, efforts will be made to investigate the methods employed by uncivilized races in their efforts to treat disease, in the hope that among the many crude measures practiced by them, some valuable remedy or procedure may be discovered.

There will be about one hundred and fifty Corresponding Editors, and sixty-four Associate Editors. The work will consist of five royal octavo volumes of about five hundred pages each, fully illustrated with wood-cuts, colored plates and maps.

The value of such a work to the profession and to humanity at large is self-evident. Supported by a syndicate of some of Pennsylvania's most distinguished citizens represented by experienced publishers, and edited by a staff of Associate Editors of the highest standing, the "Annual" possesses every quality to make it a great success.

Among the fifty-four gentlemen whe have so far accepted Associate Editorships, the following may be mentioned: Drs. L. A. Loomis, J. Lewis Smith, Francis Delafield, F. N. Otis, E. C. Seguin, Wm. H Thompson, Paul F. Munde, Lewis A. Stimson, E. L. Keyes, E. C. Spitzka, A. L. Ranney and D. Bryson Delavan, of New York; Wm. L. Richardson, F. W. Draper, and Chas. S. Minot, of Boston; N. S. Davis, of Chicago; P. S. Conner and Jas. T. Whittaker, of Cincinnati; Nicholas Senn, of Milwaukee; John B. Hamilton, of Washington; Hunter McGuire, of Richmond: John Guiteras, of Charleston; Albert L. Gihon, of Mare Island, Cal.; Christopher Johnson, of Baltimore; Wm. Pepper, D. Hayes Agnew, Wm. Goodell, Theophilus Parvin, Joseph Leidy, Wm. Thomson, J. W. Holland, Richard J. Dunglison, J. Solis Cohen, James Tyson, Wm. S. Forbes, A. Van Harlington, E. O. Shakespeare, G. W. Garretson, of Philadelphia.

The selection of articles among those published in journals, and their careful analysis for any new facts that they may contain, will form an important feature in the preparation of the final sections of the work. All papers of interest found in periodicals will be clipped out, classified, and neatly mounted in blank books. These will then be placed in the hands of the Associated Editors, each one receiving those containing articles upon subjects to which he gives, special attention, who will examine their contents carefully and collate all new facts or suggestions for their final article, in which full credit will be given to both original author and journal.

Yours very truly,

CHAS. C. SAJOUS, Chief Editor.

The above letter explains itself. The project commends itself at once to every thoughtful physician, and we doubt not that the "Annual of the Universal Medical Sciences" will be warmly welcomed. Those desiring to be subscribers should address the editor as above.

THE SPIRITUAL DOCTOR.—We no not have reference to doctors of theology but to doctors of medicine. There have recently come within our knowledge several cases in which the spirits of doctors long since deceased have, through some spiritual medium, continued their practice on earth. Since this doctor is liberated from his earthly body, he is supposed to be able to see all parts of the sick, to locate the disease in the body or mind, to give a specific treatment, and in short to do every thing in the natural treatment of a case, except sign the death certificate. Our Board of Health is not yet sufficiently enlightened to permit that. This ghostly doctor is a formidable rival to the active practitioner. Of course it requires faith in the employer; but this once acquired the rest is sure to follow. The disembodied physician charges no fees, as he needs no money income for his support.

There are only a few draw-backs to his employment by all believers. In the first place there are no spiritual druggists. We suppose the deceased druggists are all too busy with the fire-works to fill any more ℞'s. Then in place of the doctor's fee, must be paid perhaps an equal or greater amount to the medium. (It appears that all mediums are decidedly earthly, in money matters.) And lastly, these patients under this spiritual supervision do no better and die just as dead as when attended by an antemortem doctor who is able to obtain a burial permit without calling in the coroner.

On the whole, we are hopeful that our business will not be ruined by the "Spiritual Doctor."

WE extend a fraternal hand to Bros. Coomes and Marvin, who have launched on the stream of medical literature. *The Southwestern Medical Gazette*, a monthly journal of medicine and surrery. Under the management of the able editors and collaborators it is not to be wondered that the first number is spicy and readable. We wish the new journal abundant success.

MISCELLANY.

THE MEDICAL PROFESSION AND THE PROPRIETARY QUACKS.

In the *Philadelphia Medical Times* (October 16, 1886) Dr. S. S. Wallian offers some practical suggestions on the above subject. According to him, "Incomplete statistics show that the money expended by the people of the United States for secret and proprietary medical preparations aggregates annually more than eighty millions of dollars. When the reasonable statement is added that certainly more than one-half of these exploited remedies are positively detrimental rather than beneficial to their consumers, the subject becomes fairly tragic. Compared with this insidiously growing evil, war and intemperance are made to seem less formidable calamities. Observed in detail, the picture would be ludicrous if it were not in its results so fatal as to be actually appalling. For this unsatisfactory state of things there is no special or easily suggestible remedy. It may be assumed that ignorance is at the bottom of it, but it is inborn and transmitted ignorance. Generations back of us have contributed toward endowing us with a mania for dosing." Again: "There are anti-tobacco societies, anti-liquor parties, even anti-adulteration journals; but there are no anti-nostrum associations. In this connection the profession as a whole must plead guilty of a dereliction of duty. There is no doubt but by proper and persistent effort practitioners have it in their power to initiate a movement which would in time eventuate in wholesome changes in public opinion touching this vitally important subject." Two things still militate against any sweeping or sudden revolution in this direction—ignorance and tradition. But even these he holds are not utterly incurable. "Physicians themselves can accomplish much toward the desired end. Every medical practitioner owes it to his patrons, to his profession, and his conscience, to antagonize three prexailing and mischievous delusions: 1. That it is economy to doctor one's self. 2. That any remedy can be good for every ailment. 3. That irregular and unlettered 'doctors' who catch the public eye, through advertising display, owe their 'unparalled success' to the possession of chemical or other valuable secrets which are unknown to the regular profession and chemists. The practitioner ought also to inculcate a few wholesome and general precepts: 1. That to regain impaired health does not necessarily imply the use of drugs. 2. That in consulting a physician a maximum of advice and minimum of medicine is a consummation devoutly to be sought. 3. That the more intelligent people become the less they assume the responsibility of deciding questions of which only a skillful medical man is competent to judge, the less they listen to the catch-penny claims of advertising charlatans, and the less money they pay out for preparations which are not ordered or vouched for by some one in whose sagacity they confide. 4. That those who decline the use of all remedies, except when prescribed by a competent physician, experience uniformly better health, expend less money at the druggist's, and suffer infinitely less from imaginary evils than any other class. When practitioners everywhere conclude to spend more time and effort in disseminating these and similarly axiomatic truths than in traducing competitors or wrangling over medical politics, there will be less money poured into the coffers of the wily patent-medicine sharks, less quackery both in and out of the profession, and the medical millenium will draw nigh."—*N. Y. Medical Record.*

ELECTROLYTIC DESTRUCTION OF HAIRS.—L. Brocq, Paris correspondent of the *Journal of Cutaneous and Veneral Diseases*, Jan. 1887, writes: "During the past few months, I have been experimenting in Paris with the methods which the American dermatologists employ to destroy hairs growing upon regions where they should not exist. In June last, I communicated my first results to the Sociétė Méd. des Hôp. de Paris. I operate with very fine platinum needles, soldered to little metal cylinders, which make it easy, held between the thumb and index to move in any direction. So as to know the depth to which the needle has penetrated, I place, at five centimetres from the point, a mark with sealing wax. I have also had made some patinum needles with a metalic index at this point. The patient constantly holds in his hand a cylinder covered with chamois skin, attached to the positive pole. The needle attached to the opposite pole is introduced along the course of the hair down to its bulb, and the follicle is, so to speak, catheterized. An assistant now slowly turns on a current of from eight to ten milliamperes, which I usually find sufficient. In operating in this way, the patient does not suffer from the painful shocks of the current, and the pain seems to be less severe. I pass over the thousand details of the operation, on which it is not necessary to dwell, since it is especially in America that this method has been studied. The results which I have obtained have been quite satisfactory. It is incontestable that in this way the hairs can be destroyed, and indeed without leaving cicatrices to any appreciable extent, especially if care is taken not to operate at any sitting upon hairs which are close together. The inconveniences of the method consists especially in the multiplicity of operations necessary, for we can scarcely destroy more than from forty to fifty hairs at a sitting; in the intense pain which certain patients suffer, but which can, up to a certain point, be modified by interestitial injections of cocaine, and finally in the slight deformity which the inflammatory action causes, an inevitable result of the destruction of the bulb.

BELLADONNA IN THE TREATMENT OF RHUS POISONING. —

* * * In 1850 I was poisoned badly by using some leaves of the poison oak after defecation while in the woods, no paper being handy, and not knowing the bad character of the plant. On account of wiping my face, which was perspiring, the itching spread over a considerable surface of my body, face, neck, etc., and in twenty-four hours erysipelas set in. My body, legs, head, and hands and arms were enormously swollen. At this time a physician ordered a bath of salt water, which only increased the intensity of fever, pain and swelling. My grandmother came to see me, took charge of the case and made an application of the following:

Jamestown weed leaves (stramonium),
Nightshade leaves (A. belladonna),
Sweet milk.

The leaves were boiled in the milk until soft, and the entire body was covered with the preparation, using only the leaves and moistening them from time to time with the milk remaining.

For five days this treatment was continued, using twenty gallons of milk and ten bushels of the mixed leaves. I lay on an enameled cloth sheet and was covered with a sheet.

The leaves were kept on for twelve hours when they were removed (usually dry from the heat of the body), and a fresh lot put on.

I made a good recovery and was out in twelve days from date of attack of erysipelas.

No unpleasant symptoms from either of the poisonous plants used appeared.—Dr. Ben. H. Brodnax, Brodnax, La., in *Journal Cutaneous and Venereal Diseases.*

THE EFFECTS OF TOBACCO.—In a recent original investigation (*The Physiological and Pathological Effects of the Use of Tobacco,* Phila.: P. Blakiston, Son & Co., 1885), which has received the Fiske Fund Prize, Dr. Hobart Amory Hare, of Philapelphia, thus summarizes the results of his experiments upon the effects of tobacco:

1. Tobacco smoking does not decrease the urine eliminated, but rather increases it.

2. Tobacco does retard tissue waste.

3. Tobacco and its alkaloid cause convulsions in the primary stage of the poisoning, by depressing the reflex inhibitory centres in the cord.

4. It causes the palsy of the second stage by paralyzing (*a*) the motor nerve trunks, and (*b*) the motor tract of the spinal cord.

5. That the sensory nerves are not affected by the drug.

6. That nicotine contracts the pupil by stimulating the oculomotor and paralyzing the sympathetic, this action being peripheral.

7. That nicotine primarily lowers the blood pressure and pulse rate; (*a*) secondarily increases pressure and rate; (*b*) thirdly decreases pressure.

8. That the primary lowering of pressure and rate is due to pneumogastric stimulation, associated with vaso-motor dilatation.

9. That the second stage is due to vasomotor contraction and pneumogastric palsy.

10. That the third stage is due to vaso-motor dilatation returning.

11. That death in poisoning from this drug is due to failure of respiration, the action of the drug being centric.

12. That the blood corpuscles are broken up and crenated by the action of the poison.

13. That in death from nicotine poisoning the blood shows changes in *spectra*.

14. That death can be brought about by the cutaneous absorption of nicotine.

15. That tobacco in moderate amount increases intestinal peristalsis, and in poisonous doses produces tetanoid intestinal spasm.

16. That the liver seems to destroy the poison, although this destruction is participated in by any set of capillaries in other parts of the body.

17. That tobacco smoking increases pulse rate and decreases arterial pressure.—*Medical News.*

BILLROTH AND ESMARCH ON THE STUDY OF LATIN AND GREEK FOR THOSE INTENDING TO STUDY MEDICINE. — Professor Billroth has written a letter upon the above subject to Herr V. Pirquet. Billroth states that he entirely agrees with the already expressed views of Professor Esmarch, viz., "that medical language is so filled with Latin and Greek words that some knowledge of these languages is absolutely necessary for medical students; and nothing shows the parvenu more plainly than his use of foreign words of which he does not understand the meaning. Although Latin and Greek are no longer the international languages of the learned, they help to make scientific men of different nationalities understand each other, and to-day all new scientific terminology is still formed from the Greek." Billroth thinks it would be sufficient for the student to study Latin and Greek grammar, and read in Latin, Cæsar, some of Cicero, Ovid and Virgil; in Greek, Xenophon and Homer. Professor Esmarch's views coincide with those of Billroth.—*N. Y. Med. Record.*

EFFECTS OF PROLONGED LACTATION UPON THE OVARIES AND UTERUS.—Japp. Sinclair presents the following conclusions, based upon the study of a large number of cases of prolonged lactation:

1. Lactation tends to prevent conception by retarding the return of the ovaries to a condition in which ovulation is perfect.

2. After weaning, the evolution of the ovaries is much more rapid than during lactation.

3. The abrupt cessation of a prolonged lactation may be followed by an evolution of the ovaries and uterus so rapid as to induce symptoms of ovarian and uterine hyperæmia.

4. Prolonged lactation may produce a superinvolution of ovaries and uterus, and under favoring circumstances a prolapse of the latter organ. -*Revue Medicale*, Nov. 18, 1885.—*Med. News.*

INTESTINAL GIDDINESS.—The existence of this variety of giddiness has long been known to us from the occurrence of that form of it associated with or caused by the presence of worms in the intestinal tract. Leube has, however, for many years back noticed another form of it, dependent on flatulent distension and relieved by passage of flatus, and several cases which he has recently observed tend to throw some light on the subject (*Deutsches Archiv fur Klin. Medicin*). In these, three in number, the giddiness was associated with chronic constipation and relieved by free motion of the bowels or passage of flatus, with the sitting posture aggravated by the act of defecation and relieved by standing or walking, and lastly with intestinal catarrh and flatulence; and in all of them he found on examination per rectum that the feelings of giddiness were greatly intensified either by the introduction of the finger into or its withdrawal from, the rectum. He concludes, therefore, that giddiness in patients suffering from intestinal affections has its source in a diseased condition of the intestinal walls, the sensation being due to pressure on the hemorrhoidal plexus of the sympathetic nerve, but in what way brought about remains yet to be seen.—*N. Y. Med. Record.*

DIET IN DIABETES.—

Articles Permitted.—Almonds, plain, in rusks and in biscuits, bread toasted or stale macaroni.

Bacon, butter, cheese, eggs, fat and oils.

Beef tea and soups, beef, mutton, fish, game and poultry.

Cabbage, lettuce, pickles and spinach.

Custards without sugar, cream, jellies unsweetened, nuts.

Coffee, cocoa, sherry.

Articles forbidden.—Peas, beans, lentils, potatoes, sweet potatoes, celery, carrots, beets, radishes, mustard.

Oysters.

Arrow root, buckwheat, sago, tapioca, and puddings generally.

Apples, bananas and fruits generally, including raisins.

Milk, sugar, chocolate, ale, sweet wines.

Extracted from Philpot's Diet Rolls.—*Journal of Reconstructives.*

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, February, 1887. No. 5.

DENTAL DEPARTMENT.

CLAMPS AND LIGATURES.

Our attention has been called to the misuse of clamps and ligatures so often that we make no apology for offering a few suggestions in regard to the proper use of these aids in retaining the rubber in place. Many patients have suffered injury or discomfort at our hands, and in consequence thereof we throw out these words of caution. When the rubber dam is adjusted it is not necessary to tie a ligature around each tooth, especially if the operator is only going to fill a crown cavity in a bicuspid or molar. In many cases the rubber will not slip from the position in which it is placed, when a proximal cavity is to be filled anywhere in the mouth. Clamps can be dispensed with very frequently by including a large number of teeth when applying the dam. We have been present at public clinics and were much disappointed to see good operators adjust the rubber over perhaps a cuspid and two bicuspids, when they intended to fill small cavities located between the bicuspids. Then they adjusted a strong bicuspid clamp and proceeded with the operation, badly handicapped. In this class of cases the first molar and the two incisors might have been included, and a clamp would not have been necessary. All clamps, however perfect in their mechanical aspects, are more or less discomforting to a patient. Their use should be avoided whenever possible. A conical tooth in any portion of the mouth may be difficult to fill without their use, but such teeth are not numerous.

Before applying the rubber dam, particles of food, tartar, and other foreign matters, should first be removed with instruments or by syringing the mouth with tepid water; the ragged edges of cavities must be chiseled away to avoid cutting the rubber when adjusting it. We pass a waxed thread through the teeth to remove obstructions. The rubber ought to be washed, dried, and perfumed before using it. The holes may be cut or punched, as preferred, When the central incisors are to be filled, at least eight holes should be made, so that the first bicuspids may be included. This will greatly assist the operator, by giving him plenty of room in which to operate, and the teeth can be seen with ease. Ligatures are unnecessary, as the edges of the rubber may be everted so that it will cling to the teeth. In many cases untempered binding wire, such as florists use may be passed between the teeth, and by letting the ends project, twist them, and this will take the place of a clamp, with less injury to the gums, and give just as good results. We recognize the usefulness of clamps, and their necessity in certain cases, but protest against their misuse. With reference to the use of ligatures of silk or linen, our advice is, use them sparingly, as many natural festoons have been injured by their misuse, and in some cases their symmetrical outline has been permanently destroyed.—*Dental Review.*

GOLD WITH TIN AS A FILLING.

IN N. Y. ODONTOLOGICAL SOCIETY.

DR. BROPHY: The combination of gold and tin as a filling is not new. It is attracting interest in the best minds of our profession. Tin has long been regarded as a valuable material with which to fill teeth. The chief objection to it are discoloration and rapid wearing away on masticating surfaces in consequence of its softness. It is claimed that the salts of tin deposited on the interior of a tooth cavity are antiseptic, and therefore possess value as a prophylactic. Such may be the capability of the tin, but the assumption remains to be proven. I am of opinion that the efficiency of tin as a filling is caused by its softness and by its adaptation to the walls of the cavity, and therefore to its effectiveness in filling the cavity.

In a paper by Dr. W. D. Miller, of Berlin, published in the *Independent Practitioner* for August, 1884, something of the history of the use of combined gold and tin is given, in the clear and concise style characteristic of that well-known scientist. Dr. Miller asserts that gold and tin combined have been used about twenty years by Dr. F. P. Abbot, of Berlin, with satisfactory results. Dr. Miller says: "It has, however, been adopted by only a few, owing, no doubt, to a wide-spread superstition that the electricity attendant on such a filling will in some way injure the tooth." After discussing the question of electrical conditions, he adds: "We may say, therefore, that neither experimentally, theoretically, nor practically can there be any electrical action of a tin and gold filling on the tooth."

Gold and tin are prepared by placing one-fourth or more of a sheet of number four non-cohesive gold foil on the same sized piece of number four tin-foil and twisting them into a loose rope, either the tin or the gold on the outside. Frequently as much of one metal as of the other is exposed to view. The advantages claimed for the combination of tin and gold are,—that it may be inserted rapidly and with a degree of ease scarcely equalled in the use of other materials; that the presence of slight moisture does not impair the working properties of the material, nor render the filling less permanent. A short time after a tin and gold filling has been inserted both metals loose their identity; the mass expands slightly and discolors,—sometimes becomes quite black, and is converted into a crystalline substance resembling amalgam. The discoloration is *certainly objectionable*, especially on the teeth in a position exposed to view. It cannot therefore be used in the anterior teeth.

Dr. Miller's concluding paragraph is as follows:

"Gold and tin used in the manner first advocated by Dr. Abbot, of Berlin, owes its virtues to the ease and rapidity with which it may be inserted; to its marked adaptability; to its freedom from injury by moisture, and to its slight expansion after insertion, to any supposed electrical action on the tooth itself."

My limited experience with combined gold and tin will not permit me to speak of its merits as a permanent filling material with that enthusiasm and authority which mark the article from Dr. Miller, but I am convinced that by filling large proximal cavities with it we may greatly lessen our labor and relieve our patients of the tedium of protracted operations.

DR. C. R. BUTLER: The folding of tin with gold foil I regard as a bad practice, The result of my use of it somewhat after the manner of Dr. Palmer, of Syracuse, has not been satisfactory. The tin seems to disintegrate, leaving the gold standing, and gives a rugged looking surface. I use tin or textile metal along the basal border of a cavity, but without any gold mixed with it, making a square division or section of tin, and then adding gold. I think, that with careful manipulation you will find better results following that method than you will get by mixing the tin and gold.

DR. S. B. PALMER: With reference to the remarks of Dr. Butler, on the combination of gold and tin, I will say that it is not my present practice to use it as described by him. Experience has taught me that when the two metals are systematically combined, a chemical process similar to slow fusion takes place, by which an alloy is formed, unlike either metal, and nearly as hard as amalgam. I have obtained the best results by using No. 4 gold and No. 3 tin, one leaf laid on the other in alternate layers to make the thickness required, then cutting into ribbons the width most convenient. This distributes the gold and tin evenly. In rolling two or more sheets into the rope form, several thicknesses of tin are liable o; come in contact, in which case, the tin, instead of forming an alloy, will be eroded by galvanic action, and thus present the uneven surface mentioned by Dr. Butler. Whether I use gold and tin for lining cavities or for entire fillings, the same proportions are observed. By the use of cylinders made by rolling ribbons cut from the foil, as already described, at least one-half of the amalgam now used could be dispensed with. Instead of the silver-plated copper matrix referred to by Prof. Andrews, I use pure silver, which, when annealed, becomes very pliable, though I generally prefer to pass it through the rollers, and use it without annealing. It is bright in color, and answers the same purpose, without plating.

DR. BROCKWAY: Many of those who have spoken on the use of matrices in making gold fillings recognize the difficulty of making a perfect joint at the cervical wall of the cavity. I think that difficulty has beset every one who has used the matrix, and I wish to ask if it could not be overcome by the use of a thin layer of amalgam spread on that surface and filling on that with gold? Is there any valid objection to such a practice? I can see none. I have made many such fillings, and they have proved satisfactory.

I have noticed the disintegrated condition of the tin and gold fillings which has been alluded to by Drs. Palmer and Butler. Some years ago I made several such fillings, but I subsequently found they failed at the cervical margin. Not knowing how to account for this, I simply abandoned the practice. Had I known then that the use of a simple *layer* of tin and gold, as suggested by Dr. Palmer, would have prevented that disastrous condition, I should have saved myself much mortification.—*Cosmos.*

ASEPTOL.—(ORTHOXYPHENYL-SULPHUROUS OR SOZOLIC ACID).—This new phenol is an oily liquid with an ethereal odor, feebly escharotic when applied to the mucous membrane, miscible in all proportions in water, and soluble in alcohol, fixed and volatile oils and glycerine. It may be given internally in larger doses than carbolic acid, without producing toxic effects. It is twelve times more powerful as an antiseptic than carbolic acid. "Sozolic acid, in fact, besides being soluble in water, is described as combining perfectly with bases to form salts, and it is to its capability of saturating ammoniacal bases that its antiseptic action is attributed." The above seems to indicate that it would prevent nitrification in the mouth, and if so, a two or three per cent. aqueous solution might be used with advantage as a mouth-wash. When it is applied to bruised or lacerated gums, it relieves the pain very quickly; injected into the antrum, it destroys foul odors and cleanses the surfaces with great rapidity. Used as a spray for the throat or nose, it proves itself a valuable and efficient stimulant and disinfectant. No pain is produced when it is applied to an exposed pulp. It is valuable for the injection of fistulous abscesses whereever found, on account of its non-poisonous properties. Dentists will do well to experiment with this new candidate for favor.—*Dental Review.*

TOXIC EFFECTS OF CORROSIVE SUBLIMATE USED AS AN ANTISEPTIC.—This substance has come into very general use during the last few years, in the form of a solution, as an antiseptic. There can be no doubt that it possesses very considerable antiseptic powers; but, unfortunately, it is also a violent poison, and abundance of cases are now on record which show that its use is often attended with very great risk of toxic effects resulting from its absorption. In a paper recently contributed by Dr. Lucien Butte to the *Nouvelles Archives d' Obstetrique et de Gynecologie*, a long series of such cases are adduced, in many of which a fatal result followed persistent vaginal injections of the solution of Van Swieten (1 in 1000). The symptoms of poisoning were the more difficult to detect from the fact that, occurring during the puerperal period, they were masked, to some extent, by those incidental to this state. They consist principally of hypogastric pain and tenderness, violent abdominal pain of a colicky character, accompanied by frequent mucous stools, often stained with blood. The urine is generally diminished in quantity, and contains epithelial cells, casts, and more or less albumen. Salivation is most frequently absent, but the mouth and throat are red and dry, and there is marked thirst. Dr. Butte is inclined to consider that absorption occurs most frequently in cases where lacerations of the perineum, or of the cervix uteri, have taken place, or where large ulcerating surfaces are present. The toxic effects are naturally more marked in debilitated and cachectic patients. The post-mortem appearances are indicative of enteritis, with sloughing of the mucous membrane of the large intestine, while the kidneys are enlarged and anæmic. Deposits of crystals of oxalate of lime are common in the uriniferous tubules, due, it is suggested, to the decalcification of the bones, which is said to result from the presence of the bichloride in the system. As Dr. Butte quotes no fewer than twenty cases, in which the fatal result was attributed to absorption of the mercury, it is evident that, in obstetric practice at any rate, the use of even extremely dilute solutions requires very great caution.—*British Medical Journal*, June 19, 1886.

Inasmuch as a solution as weak as 1 part to 20000, bichloride mercury is still strong enough to be effective in some cases cited in medical practice, it would seem that the use of this remedy in alveolar abscess, by dentists, should be attended with a full appreciation of its dangerous character.—[ED.]

EFFECT OF MENTAL OVERWORK UPON THE TEETH.—Among the hard-worked pupils of the Paris public schools, the teeth become deteriorated in a few weeks after entry. The second dentition is often premature. These observations confirm the statements of Dr. J. L. Williams, who has given great attention to this subject. He has shown that any mental strain shows itself upon the teeth in a short time, both in increased decay, as well as in increased sensibility of the dentine. Dr. D. M. Parker has reported that these same changes are always apparent in men who are training for athletic trials. As there is not the slightest doubt of the accuracy of these observations, they show that these are matters which demand serious consideration from educators.—*Boston Medical and Surgical Journal*, June 3, 1886.

EDITORIAL.

FRANK W. SAGE, D.D.S., Editor.

INCIDENTS OF OFFICE PRACTICE.

The subjoined incidents, recalled from the writer's experience, serve to illustrate the need of careful inquiry and close discrimination in obscure cases.

Miss B., a young lady of eighteen years, called, at the suggestion of her physician, to get relief from an impacted lower wisdom tooth, to which had been attributed partial anchylosis of the jaws.

A running sore on the face, opposite the site of the offending tooth, added to the complication. The fistulous tract had been probed and repeatedly injected without appreciable benefit.

She had been under treatment about six weeks, and was able at the time we saw her to take liquid food only.

The teeth could be separated only about a quarter of an inch. It was determined to expand the jaws by gradual wedging. After about an hour's effort, this was so far accomplished as to admit of forcing in with great difficulty a straight-handled, curved-beaked forcep.

The question, which tooth to extract, the second or third molar, had, meanwhile, been in controversy.

Our friend, Dr. T., rejected our suggestion, to remove the second molar, on the ground that the abscess, supposed to be associated with the roots of the wisdom tooth, would still remain unrelieved.

This led to an investigation of the source, location, and cause of the abscess. The second molar was quite tender on percussion, while the wisdom tooth was only slightly so. A small gold filling occupied the grinding surface of the second molar. The death of the pulp under this filling would ordinarily have seemed contraindicated; still, as accompanying indications pointed to its death, we removed the filling. This proved, as we had correctly surmised, to occupy a very shallow cavity—not more than a line in depth. Nevertheless, the pulp had died, being very slightly exposed on one of its projecting *cornu*, reaching nearly to the enamel.

The tooth was extracted, and the lady recovered in all respects in a few days.

Another case, as follows, occurred in the practice of a friend in the profession.

A chronic abscess, with a fistulous opening, was treated, and apparently cured.

The tooth, an upper bicuspid, was filled (root) with gutta-percha dissolved in chloroform.

No further trouble was reported, until about two months later; the patient, a man of about forty, appeared at the dentist's office and showed the tooth, which he had had extracted in another city. The root-filling was found upon examination to be perfect.

Surprised and chagrined at his supposed failure, the dentist's curiosity was excited, and further examination of the abscess revealed an ulcerating sore on the gum, unlike an ordinary alveolar abscess.

The patient was referred to a surgeon, a malignant tumor being suspected.

The gentleman, however, neglected this advice for several weeks, and then, being driven by his necessity to consult a surgeon, he was found to be suffering from an epithelioma, which resisted all treatment and caused his death within a year.

Case III.—A physician called, suffering from an aching lower molar.

A small, shallow cavity was discovered on its distal surface, not deep enough, however, to account for the severe pain with which he had been suffering all night.

Upon percussion, he complained of an aggravation of the aching. Pulp nodules were suspected, but not being satisfied with that conclusion, further examination was made.

A medium sized amalgam filling occupied the distal aspect of its antagonist in the upper jaw. No response upon percussion, or upon application of heat and cold to this tooth. Nevertheless, we removed the filling, as a possible means of solving the mystery, when out gushed a stream of exceedingly offensive pus, and the aching in the lower tooth at once ceased.

It is to be observed that percussion, especially in the earlier stages of inflammation resulting from confined pus in a tooth. is not always a reliable test in cases where the teeth and their bony environments are of a very dense character, since the peridentium does not take on the customary phase of inflammation to a sufficient extent to be quickly responsive to a blow unless quite violent.

Case IV.—Capped an exposed pulp for a Miss of sixteen. Three weeks later she returned, complaining of severe pain when eating.

No marked response from the suspected tooth upon percusssion or upon applying heat and cold.

No decay apparent in neighboring teeth. To make sure, the dam was applied to several teeth, and after some time spent in wedging, a cavity, large, but comparatively shallow, in the first bicuspid, distal surface, was discovered.

Filled temporarily with Hill's stopping.

No further trouble.

These cases, while such as are familiar to older operators, are a few of many that occur to perplex the young operator. The lesson to be learned from such instances is, never to jump to conclusions.

Oftentimes the beginner is puzzled to know why shallow cavities on approximal surfaces should cause the severe aching of which patients complain.

A few simple experiments demonstrate that food crowding against the gum between teeth only slightly decayed may produce a degree of discomfort amounting to a positive ache.

An abscessed tooth, after prolonged treatment, will sometimes continue to annoy the patient to an extent that is only relieved by the immediate filling of the root with a non-conducting filling. It would be difficult to indicate the exact conditions under which this may be safely done, but experience teaches.

DR. HARLAN'S criticisms and suggestions on the use of the rubber dam, clamps, etc., are worth noting.

How often clamps are needlessly used!

A powerful clamp is often painful by virtue of its compressing the tooth, even when it does not impinge upon the gum at all.

We have known a patient, complaining of an aching while a pulp was being capped, to be entirely relieved by the removal of a strong clamp.

Years ago, in an essay on adjusting the dam, it was suggested that the sheet of rubber be soaped to facilitate its application; just as if that would not equally facilitate its slipping off!

An undoubted advantage is often obtained by the free use of pumice powder on a stick, or wood polishing-point, around the necks of the teeth to be encircled by the dam. Having done that, the dam will often remain in place without a ligature, where before neither ligature nor clamp would hold it.

As regards the sharp edges of a cavity cutting the rubber, we always suspect the quality of any rubber that is easily cut by an ordinary ragged edge of enamel.

Dr. Harlan's suggestion is, of course, good; we only add a suggestion, that the rubber dam is *not* always good. A piece of rubber that tears easily when it is attempted to attach it by the corners to the "holder," is not fit for use in the mouth.

An advantage, not mentioned by Dr. Harlan, of adjusting the dam to several teeth contiguous to the one to be operated upon, is the opportunity afforded for "packing" where leakage occurs at the point of last adjustment. For instance; we all know how difficult it is to prevent leakage (where the dam is adjusted to two adjoining molars) at the anterior approximal edge of the forward molar. But, if it be carried forward to include bicuspids, canine, and perhaps incisors, the leakage is either entirely avoided, or if it occurs, is so remote from the cavity being operated upon as to give no concern, being easily controlled.

The writer once saw a dentist attempt to fill a cavity in the distal surface in a first molar, the second molar being in place. He had punched a single hole in the dam, adjusted it to the tooth to be filled, and was trying to discover where the cavity in the tooth had disappeared to, when surprised by us.

But as to clamps: what an excess of ingenuity has been expended on curiously shaped clamps, which hundreds of dentists buy and never use. The idea of embracing a single tooth only, seems to dominate all inventors in this field. Cannot somebody devise a clamp with cushioned, flexible jaws (universal) adjusted to several teeth—bridging over spaces, if needs be—and steadied by wedging jaws, like those of Perry's separators, or by a brace, like Jack's regulating screws, and so on. A clamp that will not tip forward under the forward strain of the rubber, ought not to be hard to devise. Give us something that will grasp three or four teeth at once.

ON Wednesday, March 2nd prox., the Mississippi Valley Association of Dental Surgeons meets at the Ohio Dental College in this city. A prize of a twenty-five dollar gold medal is offered for the best paper on any subject pertaining to dentistry. Extraordinary efforts are being made to make the occasion one of interest and profit. The program will be announced soon. Come, and help with your presence, if nothing more, to swell the "boom" which is expected.

THE Cincinnati Odontological Society met at the office of Dr. H. A. Smith on Tuesday evening, February 1st. Dr. J. Taft read a paper on "Crown Work," which was descriptive of style of work embracing all the excellencies and devoid of numerous complications attaching to various methods now extant. After an exhibition of special appliances for this work, the members partook of a supper furnished by their host, which was enjoyed until a late hour.

THE *Dental Review* (Chicago) is out with its first number. Some of the brethren are vexed, because of an announcement as follows, which appeared in the prospectus:

"It is proposed to make the editorial department of the REVIEW an important feature; dental periodical literature has shown a deplorable lack in this regard, which it is hoped will in some measure be corrected in these pages."

In the salutatory before us, the editor says:

"The DENTAL REVIEW makes its bow with no loud blowing of trumpets, nor with promises of work to be performed which it will be unable to fulfill."

We shall watch with interest the progress of the new journal. That the editorial department is to be made an "important feature" is what perhaps most of us would naturally expect of a journal expressly devoted to reviewing. The "deplorable lack" exhibited by "periodical dental literature" must have reference rather to quality than to quantity, if the editor of the *Review* has in mind the editorial columns of the Dental Department of the Cincinnati MEDICAL AND DENTAL JOURNAL. The editor supplied about sixty pages of this journal with his own pen during the first year of its existence. Now, that we think of it, the *Ohio Journal of Dental Science* devotes some space to editorial matter, so do the *Independent Practitioner*, the *Archives*, and others. We are not informed as to whether the editors themselves of these several journals regard their editorials as an "important feature." Possibly they are all of them secretly aware that their best efforts have only availed to swell the sum total of what constitute a "deplorable lack." They will probably, however, continue to write editorials, taking fresh courage from the assurance that the *Review* "makes no promises of work to be performed which it will be unable to fulfill." Whether this is to be a work of reconstruction, or a fabric constructed of material entirely new, time will tell.

Meanwhile we take the liberty of reviewing the *Review* in one or two details of its first issue. Dr. J. E. Cravens is made the object of a rather caustic attack for reading a paper, described as "taking the palm for lack of originality," at the Indiana Dental Association. Derisive comments on his lacto-phosphate of lime treatment for exposed pulps are made. The *Review* may not be aware that Dr. Cravens publically announced in the Mississippi Valley Dental Association several years ago, that he had failed to realize his sanguine hopes for this course of treatment. That was a manly, straight-forward statement, worthy of one who must have fully realized the disadvantage of receding from a position in which he attracted the notice of the entire profession, not only in this country but abroad. We do not believe Dr. Cravens merits the aspersions of this sarcastic reviewer, whoever he may be. Just what the aforesaid reviewer means in his closing sentence, in which he speaks of "disproving the fallaciousness of his theory," we are at a loss to understand.

The *Dental Review* is a very able journal, if we may judge from this first number. We take pleasure in copying two of its articles. We assume that the paper on "Clamps and Ligatures" is by Dr. Harlan, but stand ready to make a correction if we are mistaken.

IN our March number will appear an extended notice of the second volume of the "American System of Dentistry," just received. The editor has not found time for a careful perusal of its pages, such as would warrant any more than this passing notice at present.

THE *Dental Practitioner*, of Philadelphia, is on the list of "discontinued." It ceased publication with the December number.

◆

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, March, 1887. No. 6.

MEDICAL DEPARTMENT.

LECTURES.

APOPLEXY.

BY PHILIP ZENNER, A.M., M.D.
Clinical Lecturer on Diseases of the Nervous System in the Medical College of Ohio.

GENTLEMEN:—I wish to speak to you of a condition which can not be demonstrated in the lecture room, but which is the starting point in the disease of many of the patients brought before you at the dispensary. This condition is a sudden onset of symptoms, usually both loss of consciousness and paralysis, popularly termed a "stroke." We usually speak of this condition as apoplexy, but it will be better to speak of apoplectic attacks, as the term apoplexy has come to be commonly associated with cerebral hemorrhage. But hemorrhage is only one of the two great causes of apoplectic attacks. The other, and the more common cause, is the plugging or occlusion of a blood vessel, or what we term embolism and thrombosis. We will speak of each of these conditions separately.

Embolism is the sudden plugging of a blood vessel, the plug being brought in the blood stream from a distant part. Most commonly this plug is a fibrinous deposit on the valves of the heart, which, washed into the blood stream, enters into and occludes one of the cerebral vessels, usually the left cerebral artery. Therefore embolism most frequently occurs with heart disease, and may occur at any age, in the young and in the old. Other causes of apoplectic attacks are rare in the young, so that we can usually make a diagnosis of embolism without hesitation, when an apoplectic attack occurs in one under thirty years of age. One exception to this rule we will mention immediately.

Thrombosis is the occlusion of a blood vessel by a clot, the latter forming at the seat of occlusion. In order that a clot should form it is necessary that there should be disease of the blood vessels. This occurs firstly as the result of age, a condition termed atheroma, a chronic inflammation of the artery. Atheroma is found in three-quarters of those who live beyond sixty years of age, so that thrombosis from this cause is very common. It occurs more frequently than cerebral hemorrhage. But it rarely occurs in persons less than forty years of age. The second cause of thrombosis is syphilitic disease of the arteries. This is an inflammation of the internal coat of the arteries, what is termed endertaritis. Thrombosis from this cause may occur in young persons. This, and embolism from heart disease, are almost the only causes of apoplectic attacks in young people.

Cerebral hemorrhage is due to the rupture of a blood vessel, and may be due to one of two great causes, miliary aneurisms and trauma. Careful examination of many cases of spontaneous cerebral hemorrhage has shown the presence of miliary aneurisms in every instance. These aneurisms are peculiar to the cerebral arteries. They result from an inflammation in the outer coat of the vessels, termed periarteritis. The muscular coat gradually gives way, as a result of the inflammation, and aneurismal dilitations occur. The latter are usually so small as to barely be visible to the naked eye. They occur mostly in the smaller vessels, most frequently in the arteries of the corpora striata, and it is here that hemorrhage most frequently occurs. The number of aneurisms vary greatly. There may be but one or two, or there may be hundreds. They are found in about four per cent of those beyond fifty years of age, while it is the greatest rarity to find them in persons below forty.

The other great cause of cerebral hemorrhage is trauma—injuries to the head. There is a distinct difference in the anatomical distribution of hemorrhages of spontaneous origin and those due to a blow on the head. It is very important, practically, to recognize this difference, on account of its medico-legal significance. A person is found with a scalp wound, in whom a post mortem examination reveals a cerebral hemorrhage. Did he have a sudden stroke of apoplexy, and did the scalp wound result from the fall, or did he receive a blow on the head which caused both the scalp wound and the cerebral hemorrhage? The answer of this question depends on the locality of the hemorrhage. If due to trauma it is especially on the surface of the brain. If there be a fracture of the vertex of the skull the hemorrhage is generally underneath the seat of fracture, and often between the dura mater and the skull. If there be no fracture the hemorrhage is usually on the side opposite to the seat of the blow and between the pia mater and dura mater. In hemorrhage of spontaneous origin, on the other hand, the hemorrhage is almost always in the deeper portions of the brain, generally in the corpora striata or optic thalami. The pia mater is, therefore, a dividing line. The hemorrhages beneath it are mostly spontaneous, those above it mostly due to trauma.

We will not speak farther of hemorrhage of traumatic origin, but, on account of its practical value, I wish to briefly call your attention to one point in its symptomatology. In some cases after a blow on the head has been received the patient continues on his feet, perhaps a few hours, and then begins to lose consciousness gradually, at the same time that one side of the body becomes paralyzed. Such symptoms always indicate that a blood vessel in the meninges has been ruptured on the side opposite to the hemiplegia. If a trephine be now applied and a large button of bone removed, the clot may be found and removed, further hemorrhage controlled, and a life saved, which would, otherwise, be inevitably doomed.

When we come to speak of symptoms we can not give a different symptomatology for embolism thrombosis and hemorrhage, for the conditions are so much alike that they can not be distinguished by the symptoms. It is true that the onset of symptoms is usually very sudden in embolism, but a differential diagnosis could not be based upon these points alone. Frequent concomitant conditions may enable us to make a differential diagnosis, as the age of the patient, the presence of valvular disease of the heart, or a previous history of syphilis. In giving the symptoms then I shall not try farther to distinguish those of embolism, thrombosis and lumbago, respectively.

In many instances an apoplectic stroke is ushered in like a stroke of lightning, the subject falls suddenly unconscious. More frequently it comes on less rapidly. Sometimes there are what are termed prodromes. There are attacks of headache, of vertigo, of temporary prostration, etc., symptoms which are probably due to small hemorrhages or partial occlusion of blood vessels. The attack itself may be ushered in by dimness of vision, noises in the ear, a sense of faintness, nausea, dizziness, or there may be headache, difficulty of speech, and confusion of ideas, and in a short time the patient falls to the ground entirely unconscious. He may now appear like one in a state of sleep, or, especially if the attack is severe, there may be congestion of the face, pulsating carotids, hot head, breathing slow and noisy, as well as alterations in temperature. In the beginning the temperature is usually lower than normal, but toward a fatal termination it often rises very high. There may also be a small quantity of albumen or sugar in the urine, but this is found, as a rule, only in very grave cases. Convulsions sometimes occur, either with small hemorrhages in certain parts of the brain, or with very large hemorrhages, especially if accompanied by rupture of the ventricles.

The paralyses which are brought on at this time can be more carefully observed after consciousness returns, but we need not wait for this in order to determine their presence. In the slightest cases there is paralysis of one side of the body, what is termed hemiplegia. In more severe cases the face and eyes are forcibly turned to one side, in addition to the hemiplegia. In the worst cases all the voluntary muscles are flaccid.

We are often called to see cases, where no history can be obtained, in which we are asked to make a diagnosis while the patient is still unconscious. Mistakes made on such occasions may be disastrous to the patient as as well as ruinous to the reputation of the physician. I shall therefore briefly call your attention to a few of the conditions which might be confounded with a stroke of apoplexy.

The first and most frequent is alcoholic coma. The odor of the breath will usually lead to a correct diagnosis. But alcohol may have been given for medicinal purposes, or may have been taken only moderately, it will, therefore, be well to observe whether its odor is also found in the urine as this would indicate the injestion of a large amount. If the effects of the poison be very profound there will be a considerable reduction of temperature. But it must not be forgotten that intoxication may predispose to an apoplectic attack, and if there be at the same time paralysis, etc., a complication may be suspected.

Opium poisoning causes profound coma. In this condition the pupils are very much contracted, the breathing very slow and deep, and the pulse usually slow. Some of these symptoms may be found with hemorrhage in the pons, but the latter is a very rare occurrence.

Epileptic attacks can usually be distinguished by the convulsive movements. Sometimes the latter do not accur at all, or are not observed. In epileptic attacks without convulsions there is usually extreme pallor of the face, and there is no paralysis. If the convulsion was not observed we must seek for signs of previous attacks, bruises and cicatrices on the body, cicatrices on the lips or tongue, when they had been bitten, etc. If such observations will not suffice, a short lapse of time will, generally, make the diagnosis clear.

Persons suffering with uremia often become unconscious, but in this condition headache, delirium, and convulsions are the prominent symptoms. An examination of the urine will generally reveal a large quantity of albumen, as well as the presence of casts.

Patients with diabetes mellitus sometimes die in a condition of coma, a condition termed diabetic coma. Such attacks are preceeded by dyspnœa, both the breath and the urine have a peculiar odor, like that of ether, and an examination of the urine reveals the presence of sugar. Diabetic coma occurs mostly in young persons.

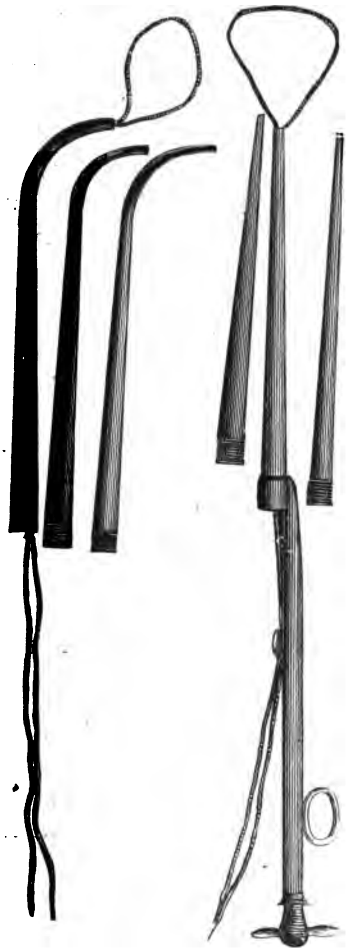
So far as to the diagnosis of various conditions which might be confounded with apoplexy. I must next attempt to point out to you what symptoms or conditions will enable us to diagnose the locality of the lesion, and especially to determine the prognosis, whether the patient will live or die, and, if he live, to what extent there will be permanent damage to the cerebral function.

◆

NOTIFICATION OF INFECTIOUS DISEASES.—In Austria the law compels the head of the household to notify the authorities in case of an infectious disease developing in his house. In this country the law compels the physician to act as a spy and to betray professional confidence by gratuitiously reporting such cases.

CARPENTER'S SNARE.

By J. B. Carpenter, M.D., Stanford, Kentucky.



The writer has invented a snare which has many advantages over Blake's or Jarvis's.

Carpenter's Snare has three straight and three curved tubes, which screw on to the body of the snare. The former tubes are for removing neoplasms from the anterior nasal cavities, mouth, external auditory canal, vagina, uterus, rectum, or integument. The latter are for removing neoplasms from the naso-pharyngeal cavities. The object in having three straight and three curved tubes is that a very fine or course wire can be used, according to circumstances; and should the wire break in snaring a fibroid, a larger size can be used by employing a larger sized tube. The screw power and the fastening of the ends of the wire are different from those of Jarvis's or Blake's. The wire is less apt to break, and much less force is required to snare a growth. This is a universal snare, and it has sufficient power to remove any growth that is suited to this method of treatment.

The length of the instrument is ten inches. The wire should be annealed before snaring; and copper wire has proved to be the strongest obtainable. Messrs. M. A. Spencer & Co., of Cincinnati, make this instrument at a cost of about $12.

EXPERIMENTAL STUDIES ON THE MAGNETISM OF THE BLOOD:

By Drs. G. Magini and A. Maggiorani, Rome.

BY A. RAVOGLI, M.D., Cincinnati.

Some considerations, in a general point of view, should precede this article, so as to explain paramagnetism or diamagnetism of bodies. The magnet attracts some bodies, as iron, nickel, cobalt, manganese, cromium, cerium, titanium, palladium, platinum, osmium, and the salts of these metals. These bodies are said to be paramagnetic, or only magnetic, having the property of arranging themselves parallel to the axes of the poles.

Other bodies are repelled from the magnet, directing themselves equatorially to the poles, and these are known as diamagnetic; among them are comprehended bismuth, antimony, zinc, tin, cadmium, mercury, lead, copper, gold, tungsten, the metalloids and their compounds, especially sulphur, phosphorous, carbon. Furthermore, water, wax, alcohol, ether, linseed oil, cyanogen, ammonia, glass without iron, wood, etc., all the organic substances, as animal matter, muscular tissue, fat, ivory, leather, blood, milk, are diamagnetic. Among the gases only oxygen, and therefore the air is paramagnetic, but all the other gases, especially hydrogen, are diamagnetic. There is another category of substances totally indifferent to magnetic action, which can be considered as amagnetic or neutral.

Studying the magnetism of bodies, it is necessary to consider always that the element in which the body is placed has an interesting rule, as was deduced from the experiments of Berguerel, made with the perchloride of iron.

An aqueous solution of perchloride of iron was paramagnetic when the surrounding solution was weaker; diamagnetic when stronger; and neutral, or amagnetic, when of the same degree of concentration.

The study of the influence of the magnet on the animal economy increased in its importance after the clinical and embryological observations of Prof. Carlo Maggiorani.

Our study was directed to establish whether the blood of the living animal showed any modification in its diamagnetic power by the use of different remedies administered internally by the stomach, by inhalation, by hypodermic injection, or by cutaneous application. Dogs, rabbits, pigeons, and frogs were subject to the experiment.

A powerful electro-magnet provided with a constant current from two large Bunsen elements was employed for the experiments. The observations were kept up for three hours, maintaining a constant current and at the same degree of intensity—a galvanometer placed in the circuit indicating its strength.

The substances were tried between the two poles of the magnet in the same way as used by Faraday, with the apparatus of Ruhmkorff. The solids were suspended by a silk thread not twised, between the poles, and the fluids were contained in small vials suspended in the same way. A glass globe protected the thread and the attached body from any possible oscillation of the air. A graduated semicircle was placed to indicate the deviations of the body under magnetic trial. A key of Dubois Reymond opened and closed the current so as to stop the magnetic power.

When the fluids were under experiment, the vial was at first tried in order to ascertain that it was entirely indifferent, then it was filled by capillarity with the fluid.

The blood of man, dog, rabbit, pigeon, and frog constantly showed the same degree of diamagnetism.

Faraday experimented on the blood of man, beef, and lamb, and was amazed to see that it was diamagnetic, when he believed it to be paramagnetic, on account of the presence of iron. Furthermore, he filtered the blood to remove the plasma and let the blood get dry, then it proved to be diamagnetic. In our experiments we found the normal diamagnetism diminished in the blood of dogs and pigeons after severe hemorrhage, and in starving frogs.

The normal diamagnetism of the animals diminished after having been immerged in different mineral waters containing iron in abundance.

Experiments were made with the alkaloids, atropia, quinine, and strychnia so as to observe the modifications of the magnetism of the blood produced by their influence.

A neutral solution of sulphate of atropia in distilled water proved to be less diamagnetic than pure distilled water. Two centigrammes of atropia were injected in the posterior legs of a small Scotch terrier, ten minutes after vomiting began, the dog was turning around, *vertigo rotaria*, and was moaning and complaining. The animal was in a hyperæsthetic condition, the posterior limbs paralyzed. The blood which before the injection proved to be diamagnetic, ten minutes after was paramagnetic. It was fluid, of dark color, and not easily coagulable. In two other dogs, subject of the same experiment, the diminution of the diamagnetism of the blood was very remarkable, but it mas not changed in paramagnetism.

Sulphate of chinine dissolved in water was injected in the dose of gr. xxx in three small dogs. After some time the blood extracted from a vein was tried, and it was remarked only that the diamagnetism was increased. The blood was found more easily coagulable. A diminution of the diamagnetic power was also found after having poisoned animals with strychnia.

Experiments with carbonic acid showed that in the animals asphyxiated the blood diminished intensely in its diamagnetism, returning to its normal degree when revived again with oxygenated air.

CONCLUSIONS:

I. There are substances capable of increasing the physiological diamagnetism of the blood, changing it sometimes to paramagnetism.

II. That there is some relation between the rapid or slow coagulation of the blood and its diamagnetic degree.

III. That carbonic acid diminishes constantly the diamagnetism of normal blood.

IV. Some mineral waters which have paramagnetic or diamagnetic power by the saline substances dissolved therin are able to modify the diamagnetic condition of the blood.

V. The alkaloids modify the diamagnetic power of the normal blood.

VI. The temperature has an influence in changing the diamagnetism of the organism.

◆

SCHOOL-MADE CHOREA.—Octavius Sturges, M.D., in the "Lancet," January 10th, 1887, reports a number of cases of chorea, traceable to school causes. Many cases in this country are doubtless due to the same cause. Among other exciting causes he mentioned: School hours too long and lessons too hard; excitement in schooling, especially at examination; punishment, especially when unmerited.

EDITORIAL.

A. B. THRASHER, A.M., M.D., - Editor.

WOMAN'S MEDICAL COLLEGE.

We have received the announcement of the Woman's Medical College of Cincinnati.

The Cincinnati College of Medicine and Surgery have admitted women to their classes for four years, but the faculty have not been pleased with lecturing before both sexes. Therefore, to "meet the increasing demand for a regular medical college in which to educate women for the practice of medicine," this college has been organized. Among the faculty are recognized mostly the names of Cincinnati College men, and that building will be used for the new school. The first session will begin February 14, 1887, following the close of the regular session of the Cincinnati College. The faculty is a good one and we wish them abundant success in their new enterprise.

That women succeed in the practice of medicine has been abundantly demonstrated in Cincinnati. There are certain departments of medicine where they seem to be peculiarly well fitted, viz., obstetrics and gynecology. Already the most of the midwifery in Cincinnati is done by women. The College will have done a good work when it has educated these midwives.

Of course the number of women who will enter the profession and remain life members will of necessity be small. No woman is capable of performing the duties of a wife and at the same time of an active practitioner of medicine. However, it would without doubt be the part of wisdom for some women to chose rather the life of a physician than to be the wife of any man. There are enough women who have a sufficient reason for not marrying, or who are widows, to fill the places open for them in the medical world. They can here find a fertile field to do life's work, and success will come to them, as to others, in proportion to the thoroughness of the work done.

MEDICAL LAWS.—Attempts at regulating the practice of medicine by law have frequently been made. The question is now again being agitated in Cincinnati.

A meeting of the profession was recently called at Lancet Hall for the consideration of medical legislation. Two factions at once made their appearance. By far the smaller one considered it prudent to invite all reputable practitioners in the different schools of medicine to take part in the proceedings. The larger faction desired only so-called "regular" physicians to have any representation in the meeting, and of course carried the day.

An effort has been made to have a law passed requiring any one desiring to practice medicine to procure a license which shall be issued by the Clerk of the Circuit Court to applicants who are graduates of medical colleges that are held as "reputable" by the State Board of Health. This law will probably pass, and will, if enforced, be productive of much good.

But since this is a matter of State legislation, and the best colleges of the different medical schools will be recognized by the State Board of Health, what is the objection to allowing members of all schools to assist in doing a good work? This coöperatian could do no harm to any one, and might help get needed legislation.

◆

FLAT CHESTS VS. EDUCATION. — Herbert Spencer says: "In its full sense the reproductive power means the power to bear a well-developed infant, and to supply that infant with the natural food for the natural period. Most of the flat chested girls who survive their high-pressure education are unable to do this." Why not say girls with undeveloped mammary glands, without reference to their education? We believe that the percentage of flat-chested girls is not increased because of education, although it may be because of luxurious or fashionable living. Too much work, either of mind or body, will doubtless decrease fertility in either sex, but we do not yet fear that our women will lose their power of nursing their children because of "high pressure education."

MISCELLANY.

THE COMPENSATION OF EXPERT WITNESSES.

We take the following piece of correspondence on the above subject from a recent number of the *N. Y. Medical Record:*

SIR: Your editorial in the MEDICAL RECORD of January 8, 1887, concerning expert testimony and its compensation, suggests to me that the following references which I have gathered may be of interest to many in the profession.

During the past year, as a member of the committee on medicolegal matters appointed by the New Mexico Medical Society, I made a diligent search for information on this topic. Here are the results:

The decision of the Supreme Court of Alabama is the only one I learned of that was wholly averse to the expert. *Ex parte* Dement, 53 Alabama, 389, is the title. The learned judges held that "in so testifying he would not be practising the healing art . . . he would be deposing only to things which he had learned in the course of his occupation or profession," etc. In Summers *vs.* State, 5 Texas (App.), 374, in 1879, the court followed the Alabama precedent closely.

The most important decision in favor of the physician was rendered in the Supreme Court of Indiana in 1877, and is entitled Buchanan *vs.* State, 59 Ind., 1. This is by far the most interesting and complete discussion of the whole subject, and should be well known by every physician. It was held that, "while a physician or surgeon could be required to attend as a witness to facts without other compensation than that provided by law for other witnesses, yet he could not be required to testify as to his professional opinion without the compensation of a professional fee. The professional knowledge of an attorney or physician is to be regarded in the light of property, and his professional services are no more at the mercy of the public, as to remuneration, than are the goods of the merchant, or the crops of the farmer, or the wares of the mechanic." "When a physician testifies as an expert by giving his opinion, he is performing a strictly professional service," the exact reverse of the Alabama decision.

Curiously enough, this acute decision of the Indiana Supreme Court did not satisfy the bucolic legislators of that State, for in their Revised Statutes, 1881, Sec. 504, is a provision that "a witness who is an expert in any art, science, trade, profession, or mystery, may be compelled to appear and testify to an opinion as such expert" without other pay than that of an ordinary witness.

In U. S. *vs.* Howe (12 Cent. L. I., 193), the United States District Court for the District of Arkansas decided in the same manner as the Indiana Supreme Court.

There are statutes in Iowa, Rhode Island, North Carolina, and South Carolina, granting extra compensation for expert witnesses; that of Iowa seems to be the best—the "compensation to be fixed by the court with reference to the value of the time employed, and the degree of learning or skill required." South Carolina fixes the pay at $10 per diem in addition to the ordinary witness fees and mileage.

The New Mexico Medical Society has prepared a bill which is now before the Legislature at Santa Fé, which provides that any person, of whatsoever trade or profession, called to testify as to his professional opinions, shall receive extra compensation to be fixed by the court, the minimum to be $10 *per diem*, the amount to be regulated by the time and skill engaged, and providing that not more than two experts can be called on a side. The object of the last provision is to prevent the accumulation of excessive costs. Its passage intact is very doubtful.

In the Indiana decision are several references to cases of interest.

Webb *vs.* Paige (1 Carrington and Kirwein, 23), an English case in 1843. The expert was a cabinet-maker, and having objected to testifying without compensation, the Court (Maule, J.) held that a witness called to depose to a "matter of opinion depending on his skill in a particular trade has, before he is examined, a right to demand from the party calling him a compensation for his loss of time, and there is a distinction between a witness thus called and a witness who is called to depose to facts which he saw."

Greenleaf on Evidence: "The latter (an expert) is under no such obligation, and the party who selects him must pay him for his time before he will be compelled to testify."

Webb *vs.* Baird, 6 Indiana, 13. In favor of the expert, in this instance an attorney.

Blythe *vs.* the State, 4 Indiana, 525. Blythe, an attorney, objected to defending a pauper by order of the court, unless compensated. The Supreme Court sustained him.

People *vs.* Montgomery, 13 Abb. Pr. (U. S.), 207 (1871). Here it was held that an expert cannot be compelled to examine a case or otherwise prepare himself for testifying.

In the Texas case above it was decided that a physician may be compelled to testify as to the result of a post-mortem examination made by him, but he cannot be compelled to make such an examination.

Also Moch *vs.* City of Buffalo, 13 Rep., 251. Haynes *vs.* Mosher, 15 How. Pr., 216.

In Re Roelker, U. S. Dist. Court, Mass., 1854, the court decided in favor of the expert, in that case an interpreter.

Editorial in *Boston Medical and Surgical Journal*, December 22, 1881, concerning case in Superior Court, Boston, Mass. Court held "that a physician is not bound to give his professional opinion for nothing in court any more than anywhere else."

Other references are: "Duties and Privileges of Expert Witnesses," *Phil. Med. Times*, January 6, 1877; Reese's "Manual of Toxicology," Philadelphia, 1874; *Phil. Med. Times*, February 11, 1882, p. 332; *Phil. Med. News*, March 11, 1882, p. 283. See also Judge C. C. Fuller's decision in Michigan, case of State *vs.* Vanimmans, where the expert was sustained, in N. Y. MEDICAL RECORD, April 3, 1886, p. 395; *American Journal of the Medical Sciences*, October, 1882, p. 546.

The standard works of Ordronaux, Med. Jur., Sec. 114, Taylor, and Wharton have passages sustaining experts in their right to extra compensation; also Redfield is named. Honeyman's Practice and Precedents, Sec. 447. Snyder *vs.* Iowa City, 40 Iowa, 616. Code of Iowa, 1873, Sec. 3814. Dille *vs.* State, 59 Indiana, 15.

From Massachusetts I learn that "the common law permits the court to allow extra fees to experts, and such a fee is always allowed witnesses for the commonwealth. Medical experts usually receive $25 a day, and those from a distance sometimes get more; but this is optional with the court, and a physician can be compelled to testify for the usual witness fee." See this discussed by F. W. Draper, M.D., in *Boston Medical and Surgical Journal*, August 2, 1883, p. 98. where the other relations of the expert witness, besides his compensation, are well considered. In the same journal, July 7, 1881, Dr. Walter Channing treats the same topic, and quotes a proposed law regulating expert testimony.

Again, in THE MEDICAL RECORD, June 25 1881, p. 722, is mentioned certain action of the Rhode Island State Medical Association.

The most complete presentation of the subject is to be found in Lawson's "Expert and Opinion Evidence," where the Indiana decision is given in full, as well as that of the Alabama Supreme Court.

I have no doubt that a more thorough search than I have been able to make, so "far from the madding crowd," would reveal much more material on this subject, in which every physician has an equal interest. To favor completeness, let me add the references to Tidy's "Legal Medicine," and Mr. Henry A. Riley's contribution on the "Law of Expert Evidenee" in the "Reference Handbook of the Medical Sciences." It is rather surprising that the opinion of an author so highly esteemed among all English-speaking people as Simon Greanleaf should not have constrained all our courts long ago to a unanimity of principle and action as regards compelling and compensating expert witnesses.

The other relations of the expert, whether as a partisan or an impartial scientific witness, his privileges and his woes in the courts, his duties and details as to his manner of giving his professional opinions, have all been much discussed also by physicians and by lawyers of liberal views.

FRANCIS H. ATKINS.

LAS VEGAS, N. M.

THE DIETARY IN CATARRH OF THE STOMACH.—T. —. McBride, M.D., in *Journal of Reconstructives.*

I.

Milk, cold or warm.

Bouillon.

Beef tea, prepared cold.

To one pound of beef tea, cut up in pieces the size of dice, add one pint of distilled water and 10 drops of dilute numatic acid. Let stand in refrigerator 24 hours; strain and season to taste, and if desired, warm, but not enough to make cloudy.

Peptonized milk.
Zwiebach, not sweetened, crackers, rusk, toast.
Natural Seltzer and Vichy waters, carbonated, distilled water.

II.

Soft boiled or raw eggs.
Rice or sago boiled soft in milk.
Clear soups.
Pureé of potato.
Vermicelli or "noodle" soups.
Calves-brains.
Sweet breads.
Pigeons, } Boiled, roast, stewed or broiled.
Chicken,
Calves feet. (?)
No vegetables except those mentioned to be allowed with soups.
No "wheaten grits," hominy, barley, oatmeal.

III.

"Minced" or finely cut boiled ham.
" " rare beefsteak.
Coffee and tea.
Articles under I and II as advised.

IV.

Rare roasted beef and veal, especially cold.
Roasted chicken, and pigeon, without sauces, especially cold.
Venison.
Partridges, woodstock and snipe, not too fresh.
Boiled fish.
White bread (stale).
Macaroni.
Baked apples.
Fruit jellies.
A very small amount of butter, otherwise no fats at any time.
Only wine; no beer, no ale or porter. Rye whiskey or brandy, dilutedwith the waters mentioned, may be used with lunch and dinner when pronounced necessary.

HYGIENE OF THE SKIN.—The skin should undergo cleansing without the chemical, and still more the physiological, properties undergoing any change thereby. The skin should remain intact. If it were simply a matter of cleansing a keratine covering of the products that are deposited on it, the use of rather sharp cleansing material would not so much matter; the surface might be slightly cauterized without injury to the lower layers. We wish, however, to remove the impurities that are deposited on the skin with out attacking the epidermis, and above all the fat contained in the epidermis must not be removed. For this purpose above all things, a neutral soap is required. There should be no question of dissolving the secretions present on the skin. Soap acts only as an emulsifying agent. It is an old experience that when tar has to be removed from the skin the tarry spot is to be rubbed with fat, because then the soap acts as a better emulsifier on the tar. Soap should be perfectly neutral, and free from foreign substances or "complementary" material. I would certainly reject the various kinds of soap in general use as hygienic toilet articles. *London Med. Press.*

A DINNER IN CENTRAL ASIA.—The people of Yarkum eat their dinner backwards; first fruit and sweets, then meat, and last of all soup.

First a colored tablecloth was spread before them, and melons, pears, grapes, apricots, and nectarines with sugared almonds and biscuits placed upon it. Next came the *entree*, consisting of minced meat delicately seasoned, done up in paste and cooked by steam. Then followed the hash or pilaff of boiled mutton and rice with shreaded carrots, the whole bringing up with a basin of thick mutton broth with barley and acid flavoring. The drink during the repast was perpetual cups of black tea.—F. C. Danvere, in *Journal of Reconstructives.*

MATERNAL IMPRESSIONS ON THE FŒTUS IN UTERO.—That maternal impressfons may affect the form, development and future character of the fœtus has been very generally accepted as true by all women in all ages, and by men, so far as they have had any idea on the subject. Medical writers with hardly an exception, down to the beginning of the eighteenth century, expressed the belief with more or less distinctness, that fœtal marks and deformations are due to the emotions, desires and shocks of the pregnant mother. Within the last twenty-five years many papers have been published in which this theory has been strongly controverted; but, Dr. Barker thought, it must be conceded that the weight of authority was in favor of the doctrine that maternal impressions may affect the development, form and character of the fœtus.

All who disbelieve the doctrine urge that deformities are due to arrest of development, but no one has brought forward any sound physiological reasons why this arrest of development may not have been caused by maternal impressions affecting fœtal nutrition by their influence on the maternal blood, as well as by falls, diseases, injuries, etc. Probably the subject had been obscured by the tendency to restrict the term "maternal impressions" to purely emotional causes, whereas it really includes those which have a physical as well as psychical origin. — *Fordyce Barker, American Gyntcological Society.*

LABOR AMONG THE NATIVES OF NEW GUINEA.—The Rev. W. S. Lawes describes, in the *Australian Medical Gazette*, of June 15, 1886, some of the customs among the natives of New Guinea in sickness and childbirth. When labor pains come on, the mother of the woman and her mother-in-law come—the former to assist the woman, the latter to receive the child. A rope is made fast to the roof and hangs at a convenient distance from the woman, so that she can hold on to it when the pains come on; her mother sits behind her, so as to support her back and head. They are always delivered sitting. When the birth is difficult (a rare occurrence even in *primipara*), a ceremony is gone through, which consists of the assembled friends performing an incantation and calling upon their ancestral god to help. It is only in extreme cases, such as malpresentation, that they endeavor to pull the child away with force. When the child is born it is received by the expectant grandmother, who sucks its mouth immediately. The cord is not cut until after the placenta has come away; when it has come the grandmother works the cord by her finger-nails until it becomes thin; she then cuts it with a piece of flint; it is not tied. The previous manipulation of the cord prevents loss of blood. The distance from the navel at which it is cut is measured on the child's thigh. Among the Motu tribe, mother and child remain in the house until the cord drops off, usually on the fifth day. Then the mother takes the child down into the sea and bathes herself and it. At Hood Point the mother takes the child in her arms as soon as it is born and plunges with it into the sea. The object is said to make it fearless of the sea. They are a tribe of fishermen. In the Gulf, to the west, they take their new-born babe to meet the breakers, and let the surf break over it. The same reason as above is given for it. Until the mother is able to feed her child, relatives and neighbors suckle the child. From the time the navel cord drops off, the child is given ripe bananas, when procurable, and very soon yams and other vegetables—all chewed first by mother or sister. Milk of animals is unknown among the natives as an article of diet. The children are really never weaned—a big boy, three years old, will come in from play and run up to his mother for a drink. The husband does not cohabit with his wife until the child is six or eight months old, and sometimes not until able to run about. They believe that it would have a prejudicial effect upon the child to do so.—*N. Y. Med. Record.*

THE NOCTURNAL COUGH OF CHILDREN.—It not infrequently happens that children are waked suddenly from quiet slumber by a violent, and sometimes convulsive, cough. This has been ascribed by McCoy to reflex irritation from accumulation of mucus within the nasal cavities. During the day the mucus flows away, but in the night it collects upon the sensitive areas in the nasal fossæ and excites a cough. Dr. Gonzalez Alvarez thinks this theory untenable, except in a few rare instances, and attributes the cough to laryngeal irritation. He says that the saliva and buccal mucus accumulate in considerable quantities, especially when there is stomatitis or gingivitis from dentition. Most of this is removed by the acts of deglutition which take place during sleep, but some does not so escape, but trickles into the posterior commissure of the larynx. He states that this cough occurs very frequently during the period of dentition, even when there is no nasal catarrh, a fact which leads him to reject the theory of nasal reflex irritation. The treatment of this nocturnal cough consists in diminishing the secretion by means of chlorate of potassium. A teaspoonful of a two per cent. solution is given every hour or two hours during the day, and at bedtime.—*Revue Bibliographique des Science Medicales*, November 22, 1885.

◆

BOOK REVIEWS.

BOOKS AND PAMPHLETS RECEIVED.

REPORT ON DISEASES OF THE RECTUM.—By Joseph M. Mathews, M. D., Professor of Principles and Practice of Surgery and Diseases of Rectum in the Kentucky School of Medicine, Louisville; Visiting Surgeon to Louisville City Hospital, and to St. Mary and Elizabeth Hospital, etc. Read before the Kentucky State Medical Society, Winchester, June, 1886.

TREATMENT OF FISSURES AND ULCERS OF THE RECTUM AND ANUS, with the Aid of an Improved Rectal Speculum. By W. S. Watson, M.D., Matteawan, N. Y. Reprint from Medical and Surgical Reporter, Dec. 25, 1886.

FOLLICULAR AMYGDALITIS.—By A. Jacobi, M.D., President of the New York Academy of Medicine. (Reprint from the Medical Record.

Professor Jacobi believes that chronic follicular amygdalitis is frequently due to diphtheritic poison which has lodged in the lacunæ and may prove a dangerous source of infection.

◆

INGENIOUS METHOD OF EXTRACTING A COCKLE-BUR FROM THE LARYNX.—Dr. D. B. Crawley, of King, Mississippi, writes us that recently a negro boy, aged nine, was brought to him with a cockle bur lodged in his larynx. His voice was almost gone, and respiration was much interfered with. With his finger introduced well down the throat, Dr. Crawley could feel the bur. Having no instruments at hand, he wrapped some cotton round the end of his right index finger, which he then passed down to the bur, and by a rotary motion he sought to entangle in the cotton the prickles of the bur, and thus withdraw it. After several attempts he succeeded in extracting the bur by this ingenious method.—*Medical News.*

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, March, 1887. No. 6.

DENTAL DEPARTMENT.

METALLIC ENAMEL SECTIONS — A NEW SYSTEM FOR FILLING TEETH.

Dr. C. H. Land, of Detroit, Mich, presents in the *Independent Practitioner* a system of applying enamel sections, to be prepared as occasion requires, for individual cases of decay. It is applicable to all cases where considerable tooth substance has been lost by decay, admitting of a pattern of the outline of the prepared cavity's being taken by means of a thin piece of annealed platinum to be burnished into the opening. Through the pattern thus obtained platinum pins are thrust, so as to project on both sides. These pins are to serve the double purpose of attaching a porcelain paste or body on the outside, and of attaching the completed piece by means of cement in the cavity. Dr. Land explains the process of baking or biscuiting, and of attaching the sections, as follows:

Having secured the prepared sections, porcelain paste or body is built upon them and carved so as to imitate the original contour of the lost portion of the tooth. They are then placed on a bed of silex and fused in a gas furnace. This requires twenty minutes for the first biscuit and fifteen for the second. When completed they will be a reproduction in porcelain of the lost parts of the natural organs, resembling nature perfectly both in color and shape. They are then cemented in the cavity, either with gutta percha filling or oxy-phosphate cement. When the anterior side of a molar or bicuspid is decayed the enameled front or veneer is added to the porcelain body. This veneer serves as a ready and efficient means of securing the proper shade and contour of each class of teeth. To those who are not familar with the use of a gas furnace this class of work may seem difficult; but a little experience with the modern appliances now within the reach of every dentist makes the operation a comparatively simple and easy one.

In bringing this new mode of practice to the notice of the dental profession I wish to call especial attention to the large amount of tooth substance preserved. In nearly all the modern systems of crown work there seems to be too much good tooth material cut away, and I think careful investigation will prove this new method to be far superior, making it possible to save the greater portion of the crown, it not being necessary to cut beneath the gum. In nearly every case sufficient tooth substance can be retained to preserve the pulp alive, and when the teeth are devitalized the major portion of the crown can be left intact, serving for retaining purposes, and making it unnecessary in the majority of cases to resort to screws or posts. Fig. 16 illustrates a section of porcelain adjusted to a central incisor, which, when carefully done makes a very acceptable piece of work. Although the joint may sometimes be conspicuous, it is not nearly as much so as a glaring piece of gold.

The numerous opportunities presented in which this procelain process will prove to be of great value is almost without limit, and has enabled me to practice dentistry on an entirely new basis, so that to-day I can say to my patients that their teeth can be perfectly restored, both in appearance and usefulness, no matter how badly they are decayed. No pulps will be destroyed, and very little tooth substance need be cut away. The use of the rubber dam is largely dispensed with, and there are no long and tedious mallet operations in large gold fillings, and no use for amalgam, yet the teeth can be perfectly restored in shape, color and size, with very little pain or fatigue either to the operator or patient.

As my labors for a higher art belong in equal proportion to my fellow co-laborers, and any improvements which I may devise will be presented to them free from the annoyance of patent rights, I take much pleasure in publishing these facts, hoping that they will be appreciated by my brethren as at least one step in the advancement of dental art.

IMPRESSIONS.

BY L. P. HASKELL, D.D.S., CHICAGO, ILL.

As the success of an artificial denture depends upon a correct impression, as the foundation of the work, care should be taken to insure success.

As to materials, I differ with many instructors. While it is true that good impressions, in some cases, can be taken with wax, more still with the modelling compound, plaster yet remains the only material reliable in all cases. In the use of the other materials it is necessary to select cases suitable for each, but if one relies upon plaster he is sure of correct results. It may be accepted as an axiom that the more difficult the case the greater the necessity for plaster to obtain an impression.

For a *full upper*, spread a large napkin over the dress, select a cup as near the size of the jaw as possible; in order to obtain a high impression over the cuspids (always a necessity), place a little wax over the outside of the cup, at those points; also over the posterior corners, if the process is prominent, and raise the palatal surface at the rear edge, if the arch is deep.

Mix the plaster to the consistency of thick cream and add a pinch of salt at the last moment, as you do not want to hasten the setting of the plaster until it is in the mouth. Stand at the right side of the chair, and with the left arm around the head of the patient, distend the lips, press the rear of the cup fully into place, telling the patient to keep the tongue quiet, and not to be concerned about what may run over at the rear, at the same time pressing the lip so as to force the plaster well up under it. If nauseated, tell the patient to resist the tendency, as it will soon be over. When the plaster has set, which can be ascertained by breaking off a piece of the surplus in front, remove by raising the lip high and working the impression so as to let the air in under it.

For a *full lower*, proceed as above, except stand in front of the patient, and as the cup is passed into place, draw the cheek away from the cup, so as to prevent a fold of membrane under it at the rear.

For a *partial lower*, with the anterior teeth remaining, select a cup with an opening for the teeth, and through which they will pass easily. Wet a piece of soft paper and lay over the opening, and holding the cup in the palm of the hand, fill in the plaster and place in the mouth, always pressing the plaster away from the front, so as to avoid as much as possible having it outside of the teeth, thus facilitating removal. If there are molars remaining and the sides of the cup will not go deep enough, place wax upon the outer edges.

In many of these cases the teeth stand in such a position that the plaster must of course break up in removal, but it matters not, only save the pieces, put them together, and a perfect impression results.

For a *partial upper:* proceed as with a full upper, remembering to press away the plaster from the sides of the cup, when there are teeth, before inserting, as enough will go outside. In these cases *do not let the plaster set as hard* as in a full set, as the cup in such case is apt to leave the impression, and it has to be removed piecemeal, which is very unpleasant to the patient.

Never take an impression in wax, and plaster in it, for while the plaster will break away as in the other case, it will be so thin in spots as to be difficult to save the pieces and replace them. There is nothing whatever gained by it.

It is a plain, simple process; only avoid using a great deal more plaster than is needed, or as large a cup as in full sets. — *Ohio Journal of Dental Science.*

TREATMENT OF PULPLESS TEETH.

DR. W. H. TAGGART, FREEPORT, IND.

In the treatment of pulpless teeth we need the very best and toughest of little broaches, and none that I have ever used are equal to those made from piano wire. They have sufficient spring to keep them from kinking or breaking off in the roots. Some dentists are in the habit of ignoring all roots into which they can not pass a *barbed* broach, saying if the canal is so small the amount of decomposed pulp can do no harm. This is a mistake; the barb on any of the broaches we buy makes that broach almost twice as large as it would be without the barb; consequently a great many roots remain uncleansed that might be just as thoroughly cleansed as larger ones by using small broaches. My way is to take the smooth broach and lay it on the bench and draw-file it with a No. 1 separating file. This makes little grooves lengthwise in the broach, and it will then hold the finest shred of cotton without any danger of its coming off, and those who have not tried these broaches will be surprised at the small canals they can follow Do not rely as much on medicines in these small roots as you do on the small, delicate broach, skillfully used. In doing this thoroughly you will find less and less need for medicines and a great deal more satisfaction.

I think considerable harm is done by some extremists in recommending remedies. Here is a dentist who might have been reasonably careful in cleansing canals by working hard. He sees an article in a magazine recommending, say iodoform. stating that it will thoroughly disinfect a root, and that it has been applied to the pulp chamber without any cleansing and the cavity sealed up, and the tooth has remained comfortable now for two months. What a bait for the dentist who is inclined to be careless. He grabs it and says all the hard work of cleansing roots is over; the consequence is that case, or any other treated in the same manner will be a failure. Another recommends bichloride of mercury to mummify the pulp. Mummify sounds very well, but beware, for tooth pulps will not *stay* mummified as the old Egyptians did. Another recommends liquid gutta percha to fill roots with—possibly as good a thing as we can use—but spoils it all by saying that it can be pumped in, and if any goes through the end of the root no trouble will follow, as it will become encysted, as even a bullet may in a man's flesh. But bear in mind that where one man lives with an encysted bullet in his body a thousand die, because the bullet would not become encysted. Be delicate and extremely careful, and remember that there never yet has been a root canal any too thoroughly cleaned and filled. Shirk nowhere; do everything as well as it can be done.—*Ind. Trans.*

◆

DARK JOINTS are caused either by poorly fitting joints or by over pressure in bringing the flask together. Some do not make their vents sufficiently free for superfluous rubber; they are in too much of a hurry in forcing the flask together. A preventive that is generally sufficient is to press into the joints a little oxyphysphate. But even this will not overcome bad work. Let us do everything neatly, carefully and skillfully, and a great many faults will disappear.—*Items of Interest.*

NEW YORK ODONTOLOGICAL SOCIETY.

Dr. C. A. Woodward introduced a patient with two inferior central incisors implanted by Dr. Younger last summer. The natural teeth had been out for some years, and the process had become absorbed to such an extent that the bone was only a line or two in thickness, making it seem as if striving for the impossible to implant a tooth with such frail surroundings. The teeth implanted were not satisfactory to Dr. Younger, as the pericentum covered but a small portion of their roots. In a few weeks they came out. Nothing daunted, however, he implanted two others, which are to-day firm, giving much comfort and satisfaction to the patient, and the gums are in a healthy condition.

Dr. N. W. Kingsley described two interesting cases in which he had the honor to perform the operations, one ot implantation and one of replantation. The first, for a lady of uncertain age, had a space between two teeth (bicuspids) which had been gradually widening for some time, but not enough to give room for a natural tooth. Wedges were used until sufficient space was obtained, when a tooth was implanted which had been extracted and embedded in a plaster model seven or eight years previously, there remaining until the opportunity came to use it for some better purpose. This tooth was implanted several years ago, and the operation has proved satisfactory to both patient and operator.

The other case was that of a lady of about the same age as the first, whose superior left central and lateral incisors stood so far out of the arch as to greatly disfigure her, and she earnestly wished their regulation. The doctor informed her that the only possible way was to extract the teeth and replant them. He therefore extracted them and formed anew the sockets for their reception. Finding the teeth too wide for the space when set back, he ground them narrower until they were well fitted, and forced them back to their places. This case had also proved a success. In both cases they were held in position by splints.—*Independent Practitioner.*

* * *

ONE KIND OF COMPARISON.—A young lady giving her experience in a dentist's chair, said it was hardly as agreeable as a box at the opera, but better than being run over by the cars.

EDITORIAL.

FRANK W. SAGE, D. D. S., - - Editor.

A QUESTION OF RESPONSIBILITY.

In the nature of things, the dentist discovers early in his practice, that he is to be held largely responsible for the results, good or bad, of his ministrations. In his ignorance of what he may or may not certainly promise, he is more than likely to place himself in an attitude towards his patrons in which complaint of failure, early or late, is sure to bring to him mortification. This is the inevitable result of an overweening confidence, and it often costs him dear. Perhaps as a student he paid the less attention to such instances of failure as met his observation, because of a vain belief in the saving grace of perfect manipulation, nicely in attention to details, and thoroughness of finish, such as he confidently expected always to observe. Wedded to the teachings of his particular school, he perhaps regarded with indifference or even contempt the opinions of those who differed in theory or practice with his preceptors. It mattered little to him that no invariable course of procedure in given instances, could be designated; he had his views of exactly what was required, and those views he adhered to with a pertinaçity born of a belief that his preceptor's opinion, or that of his favorite professor in the college, admitted of no question. This we believe, is not an exaggerated portrait of the average young graduate. Possibly we were, all of us, once equally confident, equally prepared to demonstrate that failure is the result of incompetence as invariably as success is the reward of proper attainments. Years have passed, and to most of us they have brought the unwelcome and humiliating evidence that much of what we expected to be of life-long durability, has fallen into ruin. Not all at once was the revelation made. From this quarter and from that, testimony extending through weeks and months and years, accumulated. Here a filling lost, there a capped pulp inflamed, here again an abscess like a slumbering volcano breaking out anew—all combined to rouse us at last to a full apprehension of numerous failures where we had counted upon success, The anxiously looked for end of this train of calamities was never in sight; on and on the troop marched, each day adding to the number, in an endless array. It was a new and disagreeable experience to us, and we undertook gratuitously, perhaps, the task of "making good" the loss entailed upon our patrons. Thus unwitingly did we commit ourselves to the false and unjust principle that the dentist is rightly held responsible for his failure. But after a time it probably occurred to even the most obtuse (and well-disposed) of us, that the dentist who undertakes, without compensation, to keep his work in repair, assumes more than the tailor, the boot-maker, or any other artisan. Conscience argued yes, but your patrons underwent suffering and annoyance with the understanding either implied or expressed that the work was to be durable. It matters not that you took no account of contingencies; had you known and boldly announced the uncertainty of the results, you would possibly have lost your patron. Self-interest comes to the rescue with this plea: I did not know, because I was never so taught, and I cannot assume all the responsibility. Comparing these views side by side, the dentist concludes in his unfortunate dilemma, to repudiate responsibility. I am not justly accountable, in the nature of the case, and no fair-minded person would so hold me. I will charge for all repairs just as if I had never done the work. With this determination he goes on his way, conscious that a majority of his patrons may regard his course as arbitrary and unfair. So he labors for other months and years under a disadvantage, which perhaps he never outlives.

From the consideration of numerous instances like the above, the question arises, why should the dentist be expected to be responsible for his work? The physician prescribes and fails, and prescribes again, and a fee is charged for both prescriptions alike. The lawyer is not accessible to the plea that his advice was wrong; he does not on that account remit his fee. Is the real difference after all, between the failure of the dentist and that of the other professional men, only in the tangible evidence that failure exists? We suspect it is so. But granting that the failure of the physician or of the lawyer, is frequently obvious, the fact admits of no question that the average physician or lawyer encourages no such expectations of unvarying success as are commonly held forth by dentists. The members of our profession have themselves only to blame for allowing the *onus* of responsibility for failure in the majority of cases to rest upon their own shoulders. The prevailing disposition to force the responsibility of failure upon him is the natural fruit of his own willingness to bear it. The patient who bluntly announces to his physician, "doctor, your medicine has not helped me;" does not after all expect as much by way of repairing the failure, as another who informs his dentist that a filling has fallen out. The erroneous impression so widely prevalent that dental operations ought not to fail, is mainly set afloat by the teachings and assurances of ignorant or thoughtless members of our profession. To avoid future mortification and annoyance, the dentist would act more wisely were he to frankly state the uncertainty of the final outcome of his best efforts. The truth of the matter is, many learn little by observation. A careful forecast of what may be expected from what is seen already to have occurred, does not at all enter into the calculation or many. Filling teeth does not remove predisposing causes of decay, and common sense at once cautions us to be sparing in our promises of immunity from future trouble of that kind. We may erect a fine superstructure upon a frail foundation, but we are not justly called upon to insure the foundation. At the same time it becomes the dentist's duty to call attention to the quality of the foundation, so that the patient may distinctly understand to what extent the dentist holds himself liable for failure. We hear and read much about the cause of failure –failure resulting from the recurrence of decay—but nothing has been written, to our knowledge, about fillings coming out. And yet fillings of good operators come out—are pried out, broken out—in spite of grooves, pits, and retaining screws. Who is responsible for that? Not always the dentist. The contractor who engages to build a bridge or other structure, carefully surveys the ground and notes the character of the foundation upon which he is expected to work. Probably the plans and specifications furnished him devote more attention to requirements for rendering the foundations secure than to the superstructure itself. But the dentist is furnished no plans nor specifications, and it is not within his province to improve the foundations which nature has furnished. The physician is often compelled to admit that he can only mitigate, not cure, the patient's ills. The lawyer hears his client's statement and undertakes or rejects the case according as the evidence offers prospect of relief or not. By such deliberate considerations the dentist's undertakings should be regulated. With an explicit understanding between patient and dentist, in the first place, the possibility of subsequent complaint and reproach would be largely removed.

A REQUISITE TO SUCCESS IN PRACTICE.—We have most of us seen the singular spectacle of a dentist of only ordinary skill, perhaps even a bungler, overrun with patronage. Such men are usually good talkers, discreet, and users of admirable tact. It is not by any means a loss of time to give ten or fifteen minutes to answering inquiries, making suggestions, and so preparing the way for a "full sweep" when the time for active operations arrives. A successful dentist whose field was not a large one, once explained to an inquirer that he usually calculated on doubling his bill by doing two-thirds of the work with his tongue. He was a fine dentist and the imputation of dishonesty could hardly be laid at his door. A legitimate field for the exercise of this peculiar kind of diplomacy offers when people present themselves wearing diamonds and fine apparel, with a predisposition in favor of cheap dental operations. *Verbum sap.*

MISCELLANEOUS.

TIT FOR TAT.

A Fable—By an Office Boy.

One Day a Man cum into the Bosses Offis, and says he, mister, I am A Stranger which cum A hundred 50 Miles To Get sum Teeth filled; can you do it right Away? the Boss he Thot a Minit and says he, No I'm afeard Not; I've got A all-Day appointment With judge perkinsis Wife. so The Man went of, and after a While the Boss he Got tired Waiting for miss perkins to cum, so he Went and Cleaned out the Seller, and Shuveld Cole all day. Late that Evnin Dr. Jones cum in Smokin a 15 sent sigar, and he Slapped the Boss on the Sholder, and says he, hello, sanders, you dun me A good turn Wen you Sent that Stranger over To my Offis this a.m. I Dun Forty-4 dolers an' 50c. worth Spot Cash fur him. The Boss looked Kind o' dazed Fur a Minit, and after a Bit he remarked That he be Dam if he Ever had A bit of Luck. One day About a Weak later mis perkins cum saling in Just as Me an the boss was tryin' to put a Clamp on a wisdum Tooth in a Sucker's mouth, and Says she, doctor, I'm Ol Reddy; Kin you Wait on me rite Away? I Seen he was Mad, but he Smild kind o' Pleasant, an' says He, cum in After diner an' Yu'll find The chair unoccupied. she Went of, Lookin' like she Thot that Wasn't the way She was Expectin' to be Treated. After diner she Cum in an' says kind o' commandin'; Wher's The dentist? an' says I, he's gone Fishin'. Gone Fishin'! says she turnin' red. Yes, says I; he'll be back 'bout crismus. Says she, you Tell him i've Gone to Another dentist wot's More puntchul. He'll never Do no more Work fur Our family. So There!

[This fable teaches that when you are not quite certain about the temper of your metal, it is not a bad plan to keep several irons in the fire.]

HOW SHALL IT BE DECIDED?—In view of suggestions which have been offered that experiments should be made to settle conclusively the question as to which of the numerous theories on dental decay is entitled to credence, Dr. Watt says: "This entire question ought to be and can be settled in a few months. It is a disgrace to our profession to permit the present state of facts to exist, and all the more if we let them continue."

By all means let the work be prosecuted with vigor. Conservative dentistry can never hope to attain the position of an exact science until the profession has determined exactly what are the agents they are combating in the human mouth. To our apprehension it appears probable that the truth will be reached through a modification and blending of intelligent views already published, as the result of researches by several scientists of note.—[ED.]

NOT ALWAYS THE BEST.—For carrying medicaments into roots absorbent cotton is not always best, notwithstanding it eagerly absorbs fluid preparations. It is often difficult to remove from long, narrow canals, on account of its becoming packed. Ordinary cotton is more easily removed.

REFLEX PAIN.—By Prof. Ladmore, D.D.S., L.D.S.I., Eng., in *British Journal of Dentvl Science.*

Mr. F. came to consult me on July 6th, regarding a first right upper molar, which he informed me another dentist had failed to extract after three attempts. He had been in agony for eight days, and was unable to obtain sleep. He came with the intention of having the tooth extracted, but before doing so I made an examination and thought I found two small cavities. I at once said I did not believe that tooth was the cause of the mischief, and I must look further for something more definite. He seemed to think this useless, as he was certain the pain was in that tooth. I then looked at his lower teeth, and discovered that the first and second molars on the same side were both badly decayed, the former having the pulp exposed, and evidently in a high state of inflammation. I then expressed an opinion that this was the offender and not the upper tooth. After applying an arsenic dressing I requested him to call again, which he did two days later, and informed me he had experienced no pain after leaving the operating chair. Since then I have filled the tooth, ane the result is a complete cure. The patient was surprised at the success, and said he was glad the other dentist was unable to extract the upper tooth.

BIBLIOGRAPHY.

THE AMERICAN SYSTEM OF DENTISTRY. Vol. II. Edited by Wilbur F. Litch, M.D., D.D.S. Published by Lea Bros. & Co.

This, the second volume of the series already announced, contains 1100 pages of reading matter under the two leading heads of Operative and Prosthetic Dentistry. Part First is devoted to Operative Dentistry, the subject being sub-divided and treated under nine heads or chapters, by various authors. Part Second, on Prosthetic Dentistry, is subdivided into sixteen chapters. As would naturally be expected in a work of this size and scope, everything that pertains to the two fields of dental practice finds a place for consideration. It is a work fully up to the times, and is in itself an encyclopædia of dental knowledge. The second volume is full of practical suggestions and valuable information for both old and young practitioners.

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, April, 1887. No. 7.

MEDICAL DEPARTMENT.

THE MEDICAL PROFESSION.

A Response to a Toast at the Pharmaceutical Banquet, March 17, 1887.

BY JAMES T. WHITTAKER, M.D.

Mr. Chairman:—In rising to respond to this toast I feel almost as though pledging my own prosperity. For the practice of medicine and pharmacy are one. We are all members of the same family. Perhaps the fact that this is St. Patrick's day explains the situation. For you all know the long and bitter war which contested the exact day of his birth—whether the 8th or the 9th—was finally settled by the priest with the advice: "Don't be always dividin' but rather combine. For a man can't have two birthdays, barin' its twins." I shall, therefore, not speak of any contentions or disagreements that may exist between us, but of the reproaches heaped upon us all combined, and more especially of our mutual relations of furnishers and administrators of drugs.

The scholar of Shakespeare may wonder that when the physician came to Cymbeline, king of Britain, with the news of the queen's death, he was about to reproach the medical man with the inefficiency of his art, when he stopped, reflected, and said quickly, "But I consider by medicine life may be prolonged,"—in the evident sense, too, not of a protraction of its natural span but of a cure of the maladies which cut it short. Some consolation or exculpation he got also from the fact that "death seizes the doctor, too."

The tendency of our day more than then is to decry drugs. It has become quite an evidence of superior intelligence to feel a degree of contempt for the individual who appeals to a remedy for any ailment. Then so much is said and written concerning hygiene that the belief prevails that nothing else is useful, or, as Rousseau puts it, "*la partie utile de la medecine c'est la hygiene.*"

This increduality regarding the value of medicine is a natural reaction from the blind faith in their virtues of centuries gone by. It is the natural rebound from superstition to skepticism on the part, too, rather of the half than the wholly educated, more especially on the part of the litterateurs of the popular, which is generally the pseudo-scientific journal. Popular beliefs are nearly always old or antiquated professional beliefs, and the people who decry drugs base their disbelief, so far as they reason at all, on the effect or lack of effect of agents which are scarcely used at all in the practice of our day.

Hygiene is, of course, a cardinal factor in modern medicine, but hygiene has far more to do with the prevention than with the cure of disease. So far as concerns the cure of disease, the attempt to effect it without drugs is the attempt to make bricks without straw. With prophylaxis we have nothing to do here.

What I maintain is, there never was a time in the history of medicine when drugs were so potent for good as they are to-day. When to use them is the education of the physician. "*Utilis est medicina*" said Paligemas, "*suo quæ tempore venit.*" The scale is turned in favor of life every day by the right administration of the right drug. We have learned a good deal from the observation of the natural history of disease. We have learned a good deal from morbid anatomy. But the man who loses himself in the study of these things, resolves his practice, as Aristophanes said, "into the contemplation of death."

Perhaps you will allow me, by way of illustration, to select almost at random, three of our most common diseases, and first a malarial fever. The natural history of the disease is to run on for months, consuming the body day by day, poisoning the blood and through it the brain, making life a burden—even in its masked forms.

Quinine, rightly administered, cures it absolutely.

Next, dysentery, the disease that stalks like a specter in the train of armies, killing more than the enemy's guns, and often enough a scourge in civil life. It is known by its tortures, its progressive emaciation, its great mortality. There are many ways of treating its various forms, many cases are obstinates but there is probably not a practitioner of medicine in this city or State who has not seen cases of monthly duration cut short and cured absolutely by a single day's administration of ipecac.

Lastly, let me turn to a self limited disease, which they are not. Let me take also an affection for which there is no known cure in the sense of cutting it short—typhoid fever. It runs its course in three weeks. The cause of it, which is now definitely known, expires in the body in twenty-one days, and if the patient can be sustained during all this time he will probably recover. That is, he has, as Griesinger puts it, four chances in his favor and one against him. Under what is known as the expectant treatment, the mortality of typhoid fever is 20 per cent. Then what is the use of drugs in a disease which cures itself?

There are many dangers in typhoid fever; one is hemorrhage, hemorrhage we check by ergot; one is peritonitis, which we may often relieve by opium. But the great danger is fever — fever which burns up the body, consumes more especially the heart. We have, as yet, as stated, no specific for typhoid fever—nothing to kill the cause without also killing the body, but pharmacy has recently furnished us with one of its most remarkable contributions—the means for holding the fever down to any desired degree. And with what result? With the astonishing result that with proper antipyretic treatment the mortality of typhoid fever is brought down to five per cent. When I began the study of medicine twenty-five years ago the mortality of typhoid fever was thirty to forty per cent, or as great as that of cholera or the plague.

You know as well as I how easy it would be to multiply examples of this kind.

So, I repeat, the man who decries drugs publishes his own ignorance.

To furnish the materia medica is the office of the pharmacist.

In looking over the history of pharmacy it is impossible not to see the great change which has taken place in the character of this material. The first drugs were the simples and herbs which our grandmothers still employ. Infancy still shudders at these nauseating potions. Stomachs were stuffed with the bushel of chaff for its peradventure grain of wheat—stuffed as the herbivora are stuffed with hay, without their vast reservoirs in which to digest.

Next came the isolation of the active principles in the various alkaloids, which made an immense stride for pharmacy and raised it at once to the dignity of a science.

And now comes that period of the total disregard for natural products in the manufactures of the laboratory. The pharmaceutical chemists have learned the secrets of grouping elements, whereby they steal the fire of heaven itself. Already they have given us chloroform, chloral, and above all that remarkable group of remedies known as the antipyretics. We had nothing in the old regime in the treatment of fevers but blood letting, tartar emetic and antimony. More recently came the cold bath. Blood-letting, antimony and veratrum are powerful antipyretics, but look at what cost. They lower the temperature, but only by lowering the force of the heart. They strike down the fever but they also strike down the support of the whole body, the central organ of the circulation, which is already struggling, crippled, to supply the demand for blood. It was a cruel thing to have to attack fever by attacking the heart. Cold baths remained the only safe antipyretics. But the prejudice against the cold bath constitutes an insuperable obstacle to its use. Every accident after it was attributed to it. Cold baths with us at least are absolutely impracticable. Next the experimenter showed us that we had in large doses of quinine a substitute not so reliable but less objectionable. But quinine in large doses has its evils, the distress of cinchonism, the lack of continuous action, and as I have said, it often fails. Next the pharmaceutical chemists gave us kairin, thallin, antipyrine, and last and best of all, a peculiar agent, acetanidide, the product of the action of acetic acid upon anidine, commonly known as antifebrine, which is the quickest, safest and pleasantest in its action, leaves nothing further to be desired, unless, indeed, some antimycotic agent strictly speaking, the discovery of which must be only a matter of time.

But, gentlemen, let me not forget that the old Greek word, pharmakon, meant not only a drug but a charm, and the pharmacists were the dispensers of charms. Let me acknowledge my appreciation of them in the pleasure I have had in meeting with you to-night.

A CASE OF MULTIPLE EPITHELIUM OF THE GUM.

By DR. J. A. THOMPSON, Cincinnati.

Mrs. M. T., aged fifty-seven, came to my office February 1st, complaining of something that looked like a wart on the gum of her upper jaw. She gave the following history: There is no record of tuberculosis or malignant growth in her family. The only disease from which she has suffered in recent years is malaria. This she contracted twenty years ago while living in Memphis, Tenn., and has suffered from different forms of malarial disease at intervals since that time.

Eight years ago the last of her upper teeth were removed, and since that time she has worn a plate. There is almost no arch to her palate, and she has always had trouble in keeping the plate in position. A number of different devices have been tried to secure the requisite suction but none were successful. She has had four sets of teeth in eight years, all on rubber plates, but none were satisfactory. About eight months before consulting me she noticed an increased difficulty in retaining the plate in its proper position. Her daughter told her that her teeth appeared too prominent when in her mouth.

She quit wearing the teeth except at meal time, lest they should fall out and be broken.

The day she first consulted me, while combing her hair she was prompted by curiosity to examine her mouth in a hand mirrror. She discovered a little projection in the region of the right upper canine tooth. It had never given her any pain of trouble, but thinking it might be the cause of the increasing difficulty in retaining her teeth in position, she came to ask if I thought it advisable to remove it. I found on inspection a row of nodules, seven in number, extending from the position of the first molar on the right side around the arch ot the gum to the position of the left bicuspids. The nodules were of almost equal size, except the one discovered by the patient, which was half as large again as the others. They were about the size of peas and cartilaginous in hardness.

The cancerous nature ot the growth was at once suspected, and I suggested the propriety of removing a small portion for microscopic examination. To this the patient at first demurred, but finally consented. The specimen was referred to Dr. J. C. Oliver, microscopist of the Cincinnati Hospital, for examination. He pronounced it an epithelioma. An operation was advised, and one week after I first saw the patient, assisted by Drs. Oliver and Wenning, I removed the growth. The patient was given morphia grs. 1-6, hypodermically, and then anæsthetszed by the mixed anæsthetic. The mouth was held open by medium sized corks placed far back between the jaws. Threads had previously been drawn through the corks and were brought out at the angles of the mouth and looped over the ears to prevent them being swallowed.

The mouth was then loosely packed with sponge to prevent blood being drawn into the trachea. The upper lip was retracted and the growth removed by the knife. The incisions were made beginning low down on the palatal surface to prevent the field of operation being obscured by blood. It was found necessary to remove all the tissues down to the bone before those present were sure all the malignant growth was destroyed. The hemorrhage was very profuse. It was controlled by twisting the bleeding vessels and applying pressure. Finally to check a persistent oozing the compound tincture of iodine was applied directly to the wound. The cut surface was about two inches long and half an inch wide. No attempt was made to close the wound for lack of tissue to draw together.

As it is impossible to carry out full the details of antiseptic surgery in the mouth, no attempt at antisepsis was made, but the result was as good as could have been anticipated under the most favorable conditions. The only dressing applied was a little roll of cotton moistened with the following solution:

℞ Acidi Borici, ʒss.;
Aquæ. Dest., ʒss.;
M. Ft. Sol.;
Add Glycerine, ʒss.
S. For local use.

The roll of cotton was held in place by the pressure of the lower teeth.

The only only other application made was to touch some exuberant granulations three or four times with powdered boric acid.

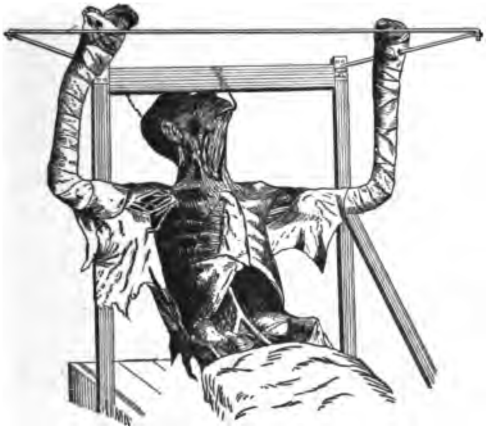
The wound healed in two weeks without giving one hour of pain, and without having secreted a drop of pus.

The shock of the operation precipitated an attack of tertian intermittent fever, with which the patient had been previously threatened for some days. It was controlled by quinine, and except during the paroxysm, she never showed any elevation of temperature

The value, pathologically, of this case, is in its history of long continued local irritation producing a malignant growth in one whose family history gives no hereditary influence favoring such production, and in the existence of separate foce, whose size and position showed they were not the result of infection from a common center, but originated *de novo*.

CONCERNING ANATOMICAL DEMONSTRATIONS.

By KONN B. SAYRES, M.D., Cincinnati, O.



The accompanying photograph illustrates a mode of exhibiting regional dissections in the upright position before a private class or in the general college lecture room. The upright yoke fits accurately to the table when laid flat and is on the same plane. When raised to the perpendicular it is sustained by a suitable brace properly secured.

The cadaver or sections of it may be shown suspended in the upright position, and, furthermore, by means of the revolving table, may be exposed in anterior, lateral, or posterior view, so as to face any part of the auditorium or any light desired.

Regional and surgical dissections, with all their relations, may be thus displayed better than in any other manner. This plan was adopted some years since by the writer while teaching a private class in anatomy, and has been followed by him in preparing and exhibiting dissections for the lectures of Prof. Langdon, of the Miami Medical College, during the present winter course.

There are many exposures which may thus be shown, with much greater advantage and effect than when the body is lying prone upon the table, and the amount of interest awakened among observing students by this new departure during the past winter, has been very marked. As the plan is, so far as I can learn, original, and has not been adopted elsewhere, and as the proper and "highest study of mankind is man," several gentlemen interested in the study and teaching of anatomy have requested me to prepare this article for publication.

No. 70 West Seventh St.,
February 21, 1887.

* * *

DIET FOR OBESITY.—Dr. Ebstein recommends the following:

1. *Breakfast.*—In winter at half-past seven, in summer at half-past six, a large cup of black tea, without sugar or milk, 50 grammes (nearly two ounces) of white or brown bread toasted, with plenty of butter.

2. *Dinner.*—Two to half-past two, soup (often of bone marrow), 120 to 180 grammes (from 4 to six ounces) of roast or boiled meat, with a fat sauce to fat meat preferred; vegetables in moderation, preferably the luguminous; also cabbage. Carrots almost proscribed; potatoes entirely so. For dessert, fruit is permitted, fruit stewed without sugar, or a salad. As a drink, two or three glasses of light, white wine. Also after dinner a large cup of black tea, without milk or sugar.

Supper.—Half-past seven to eight. In winter almost regularly, in summer occasionally, a large cup of black tea, without milk or sugar. An egg or a piece of fat meat, or even both. A little fat ham, sausage, or fish smoked or fresh; about 30 grammes (an ounce) of white bread, with plenty of butter; finally, a little tea or fresh fruit.

APHONIA FROM SUBGLOTTIC GROWTH.—G. A. Carpenter, M.R.C.S., in *The Lancet*, March 12th, 1887, reports a subglottic pedunculated tumor in a patient eighteen years old, who had only been able to speak in a whisper up to ten years of age, since when she had a hoarse voice. The removal of the tumor restored her voice. The inference was that the tumor was congenital.

EDITORIAL.

A. B. THRASHER, A.M., M.D., Editor.

CINCINNATI HOSPITAL AND THE MEDICAL COLLEGES.

An effort is being made to have the different medical colleges of Cincinnati represented on the Hospital staff just in proportion to the number of matriculants at each college.

Of course this effort is by the Ohio Medical College, as the Miami now has control at the Hospital, and other colleges are not represented.

The present Board of Trustees seem to favor the Miami College. Of the fourteen gentlemen composing the staff, eight are directly connected with the Miami College, and two more are in close sympathy with that institution; two hold positions in the Ohio College, and the remaining two are not connected with any college.

Now a *pro rata* division of the staff positions among the various medical colleges would make quite a change in the existing conditions. In the first place the Hospital is a public institution, supported by a general city tax. Then why should there be a discrimination against any college of medicine in the city? The Homeopathic, the Eclectic, the Vitropathic, the Woman's Medicol College—all these could claim representation on the newly organized staff. How many of the gentlemen on the present staff would serve on the above conditions?

We think this way out of the present dilemma is more dangerous than the dilemma itself.

We humbly offer as a substitute for the *pro rata* plan the following: That the Board of Public Affairs appoint on the staff of the Hospital reputable medical gentlemen who are capable of giving clinical lectures, without regard to any school of medicine; that the appointments be for a period of five years; that each staff physician be paid $4,000 yearly for his professional services.

By this means gentlemen of ability could be secured without placing the city in the position of accepting charity from the medical profession. The public would be taught that medical services have a moneyed value, and physicians would no longer regard a hospital appointment as a mere advertisement of his private practice, but would expect to do so much honest work for so much good money.

THE CINCINNATI MORGUE. — The new Cincinnati morgue is pretty well completed. But now there seems to be some hesitation as to the cooling and ventilation of the exhibition room.

In the Paris morgue the bodies are frozen and exposed on marble slabs with ice water running over them. This method has been proposed here. The method in vogue for cooling beer cellars and making artifical ice has also been thought of, by running pipes throughout the building and cooling them by the use of chemicals. But another method has been suggested, and is now under consideration by which the temperature of the dead room can be kept as low as desirable, and thorough ventilation secured at the same time. This is by means of a cold air blast, caused by the mechanical expansion of a volume of air which has been very highly condensed. By this means a current of pure, dry air at a very low temperature can be kept in circulation and carried away by a ventilating shaft, thus insuring the very conditions most desirable, i.e., low temperature, dryness of atmosphere, and perfect ventilation.

We hope the committee may see fit to decide on the last method, which, together with the very complete and admirably arranged building, would give Cincinnati one of the very best morgues in this or any other country.

DRS. R. B. DAVY and M. B. Keller, two of our esteemed coworkers, and members of the Academy of Medicine, have located in San Diego, California, where they propose opening a sanitarium. Their business and professional ability is such as to insure their success. Eastern physicians can confidently place their patients travelling in California in charge of these gentlemen.

MINNESOTA MEDICAL LAWS. — The Minnesota legislature has passod a law for the appointment of a State Board of Medical Examiners. Two of the members must be homeopaths, and none must be connected with any medical college. All persons hereafter commencing the practice of medicine in the State must be examined by this Board.

This is the only sensible state law, one in which the power to grant a license is entirely separated from the medical colleges. We should go still further and place the sole power to grant a medical degree in the hands of such a board. Then will we hope to see better work done in our medical colleges and our degrees rank with those of other countries.

ICHTHYOL.—This remedy is prepared from a bituminous deposit, discovered by Dr. K. Schroeter near Seefeld, in Tyrol. The deposit appears to consist of immense layers of petrified antediluvian fishes and marine animals found 5,000 feet above the present level of the sea, the species there found having been extinct for ages. The remedy was first tried by Dr. P. G. Unna, Director of the Institute for skin-diseases in Hamburg, who was the first to draw the attention of the scientific world to its effects. It is used both internally and externally in the various forms of rheumatism, gout, etc., and in parasitic skin-diseases, eczema, etc., in various dilutions with water, or with the usual excipients, employed in making ointments, such as lanolin, petroleum, simple cerate, etc.

The curative properties seem to depend upon the large amount of sulphur, presented in a soluble form. The remedy may be used for considerable time without producing any deleterious effects whatsoever.

Two varieties of ichthyol are found in commere, differing from each other in respect to their base. The sulpho-ichthyolate of sodium is generally labeled Natr. Sulfo-ichthyolic. The sulpho-ichthyolate of ammonium (labeled Ammon. Sulpho-ichthyolic), is now mostly preferred.—*Med. Clippings and New Chemicals.*

DYSPHAGIA OF PHARYNGEAL PHTHISIS.—This distressing symptom has been in one case (*The Lancet*, March 5th, 1887) relieved by Mr. Lennox Browne, of London, by first scraping the diseased surface—after having applied cocaine—and then touching it with a strong solution of lactic acid (20 to 60 per cent.) daily. At the end of the end of three weeks the dysphagia was entirely relieved.

MISCELLANEOUS.

THE THERAPEUTIC VALUE OF OXYGEN.

With Reports of Cases Treated.

By SAMUEL S. WALLIAN, A.M. M.D., of New York.

Regarding the availibility and applicability of factitious oxygen as a therapeutic agent, there has prevailed and still prevails a very general misconception. This stereotyped estimate is based on the reports of early investigators, particularly those of Lavoisier, who asserted that his birds, dogs, rabbits and guinea pigs, when immersed for a short time in an appartment or receiver filled with crude oxygen gas (derived from and doubtless tainted by the bungling decomposition of an oxide of mercury) became excited and preternaturally lively, which condition was followed by more or less physiological depression. Considering the crude state of chemical science at that time, and the questionable processes employed, it is easy to understand that these results were not necessarily attributable to the newly discovered gas, the nature of which was being eagerly and none too honestly investigated. * *

The later French and German authorities have not added much to our knowledge of the agent, their experiments partaking more of the brilliantly curious than of the practical form. Some of them have shown, at least to their own satisfaction, that there is a saturation point, beyond which it refuses to absorb any more oxygen; overlooking the imminent and practical fact that the average human being, living under ordinary civilized circumstances, seldom approximates the saturation point, and that ordinary mortals are in about as much danger of being translated as of damaging themselves by an excess of the vital element in question. To this dead level of authorities there are a few notable exceptions. Phillips cautiously but convincingly combats the prevailing misconceptions and our own Dalton refutes many of the absurd conclusions which had so long prevailed. It is now known that the decarbonization of the blood is not the principal office of the oxygen derived from atmospheric inspiration. The experiments of Magnus show that from ten to twenty-five per cent. of the oxygen inhaled by a human adult is absorbed directly and in a free state into the blood. The affinity of the blood, arterial as well as venous, for oxygen is shown to be very great. Compared with that of water the ratio is as as 2½ to one. This is doubtless the keynote to the action of oxygen, therapeutically exhibited.

Dalton has shown that the carbon dioxide constantly exhaled by all animal bodies, is not at all formed by contact of the circulating fluid with the oxygen of the air. *It already exists in venous blood before it reaches the lungs.* Hence it is constantly being formed in the tissues themselves, as well as in arterial blood; since the same authority shows that both carbon dioxide and free oxygen exist in arterial blood. According to Magnus there is a nearly constant relation existing between them, the mean proportion being, by volume, as 10 to 25 in arterial and as 10 to 40 in venous blood.

If these premises be accepted, and no one has as yet disputed them, carbon di-oxide is not, as is generally taught, wholly the product of respiration. No doubt a small portion of that expired is formed at the moment of contact of atmospheric oxygen with the carbon loaded blood as it reaches the air cell, but more of it already exists in the circulating fluid. The venous system is thus seen to be a collector of waste products—the complex sewerage of the vital economy. In the pulmonary circulation oxygen is freely and promptly absorbed, and carbon dioxide given off, while in the systemic circulation the oxygen disappears and is constantly being utilized in the various processes of reconstruction.

It is evident that the ancient assumption regarding vital combustion is very imperfect as an explanation of the office of oxygen. In fact, modern physiologists have proved that the whole theory of heat production in the animal system, considered as a direct result of combustion, is lame and unsatisfactory. It is a well known law of physics as well as of common observation, that slow oxidation is not the source of any considerable degree of heat, and vital caloric has another explanation than that of combustion of carbonized material within the system.

What becomes of the 10 to 25 per cent of oxygen so constantly absorbed by the blood? Is its office to supervise the general processes of the metamorphosis, without which the animal can not exist? Does it preside alike over digestion and assimilation, and does the absence of it render possible all the various forms of mal-assimilation, including those which result in glycosuria, lithæmia and the various diatheses—even the tubercular? Does it incidentally, here as elsewhere in nature, intercept toxic tendencies, destroy septic and putrefactive germs, prevent degenerative changes, and retard or render inert the slowly forming elements of malignant growth? Is it used in the end as an essential *materia alimentaria?* These are questions which have been asked, which are, in fact, constantly being insinuated by science, but have, as yet, been only empirically rather than satisfactorily or scientifically answered. * * *

It is evident to the most casual observer that the medical science of the future must be largely based on a study of natural therapeutics. The artifical and far fetched are daily losing caste. The profession long since lost faith in dispensatory routine, and the lay public is gradually becoming infected with the same skepticism. The heydey of pharmacomania has passed and the inevitable reaction has already set in. The routinists no longer take front rank. They must henceforth become the rear guard and camp followers of the army of progress. Without realizing it, the profession is quite generally recommending oxygen. Every patient sent on a sea-voyage or to the mountains, is a walking certificate as to its efficacy. Every argument in favor of open air life, roughing it on the plains, a sojourn in Southern California, Italy—in short—all travel, is a plea for oxygen. Many of the newer antiseptics and parasiticides have been found to depend on free oxygen liberated during decomposition within the system, or in contact with the tissues. The terebene group may be cited as an example. Theories, however, are not so important as clinical facts. A few brief sketches of further cases treated are appended.

Case 21. — Mrs. S., age 32, suffering from chronic gastric catarrh of unusually severe type. After six weeks' daily use of oxygen (modified and diluted), together with hot water drinking—very little attention being paid to her diet—she fully recovered and became more robust than she had been for many years.

Case 22. Mrs. C. R., age 63. Suffered some years since with spinal meningitis and has never fully recovered. Convalescence was followed by epileptoid convulsions and hysterical phenomena of various kinds. At present is subject to paroxysms of dyspnœa simulating œdema of the lungs. Each paroxysm it is thought will prove fatal. Modified oxygen was carried to the bedside in rubber bags twice daily, and during the intervals the patient was kept supplied with a solution of hydrogen dioxide which was vaporized and inhaled.

This treaiment was continued for three weeks, with the gratifying result of clearing up the lungs, removing the dyspnœa, and greatly aiding the digestion, which had become seriously disordered. Nor was there any relapse after leaving off the remedy. The patient died six months later from degeneration of the cord (at least so reported by the attending physician), the dyspnœa not having returned.

Case 23. P. E., age 32. Subject to periodic headaches of so severe a type as to have injured his memory and caused ocular troubles. The paroxysms are generally a true migraine, and of fairly explosive violence. They recur from once to three times a week quite regularly. Placed this patient on a mixture of O, N_2O and common air, viz.:

℞. O, two volumes.
N_2O, one volume.
Common air, three volumes. ♍.

Of which two to four gallons were inhaled night and morning.

Two weeks' treatment generally relieved the paroxysms, and in four weeks patient assures me he is no longer troubled. The head is cool, the eyes clear, and the paroxysms do not now occur.

Case 24.—Miss W. M., age 24, teacher. Has severe and constant cough, with "soreness" of the lungs, loss of appetite and general malaise. Is very much frightened lest it be already incurably seated "consumption." The family history is not favorable.

October 20.—Not being able to come to the office for treatment, is placed upon the daily use of the portable variety. Continuing the inhalations carefully night and morning for four weeks, she reports that her cough is gone and appetite excellent. The soreness no longer troubles her, and she has given up "dying of consumption" for the present.

Case 25.—Mrs. W. A., age 62. Has been for years subject to constant neuralgia—trifacial—of the most aggravated form, accompanied by severe chronic dyspepsia. Stomach tolerates very little food of any kind, and her sufferings are agonized in the extreme. It is hardly thought that treatment will do much for her, especially since her circumstances do not permit the most efficient form of office treatment. Contrary to expectation, the thorough use of the portable form of oxygen four times a day is followed by marked and immediate relief of the paroxysms. The digestive system also promptly responds, and within a week or ten days she is enabled to partake of nourishing diet, and to digest it. In connection with the inhalations this patient is directed to take internally, of the 15 volume solution of hydrogen dioxide, a teasponnful, well diluted, before each meal.

This treatment is still being followed and improvement is steady in all directions.

The Wallian oxygen apparatus and supplies can be obtained of M. A. Spencer & Co., Cincinnati.

BOOK REVIEWS.

? QUIZ COMPENDS ?

A COMPEND OF SURGERY. For students and physicians. By Orville Howitz, B.S., M.D., Demonstrator of Anatomy in Jefferson Medical College, etc., etc. Third edition. Thoroughly revised, enlarged and improved, with ninety-one illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street.

A COMPEND OF OBSTETRICS. Especially adapted to the use of medical students and physicians. By Henry G. Landis, A.M., M.D., Late Professor of Obstetrics and Diseases of Women in Starling Medical College, etc., etc. Third edition, thoroughly revised, with new Illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street.

The above two condensed works can only prove of advantage to advanced students, who want to hastily review the subject, or to physicians, who have forgotten what they knew on the subject, and have not the facilities or the inclination to search larger works. To all such we cordially commend the ? Quiz Compends ?

THE

CINCINNATI

Medical and Dental

JOURNAL.

Vol. II. Cincinnati, April, 1887. No. 7.

DENTAL DEPARTMENT.

ROTATION AS A CONDENSING FORCE.

By JAMES TRUMAN, D. D. S., *in Penn. Odontological Society.*

The introduction of the method of rotation by Dr. Wm. Herbst, of Bremen, has been followed naturally by a great variety of opinions as to its merits. Some of these, doubtless, have been the result of actual experiment, and others of observation; but from whatever source they have been derived, it must be conceded that the subject has been generously met, and the inventor recognized as an original thinker, an indefatigable worker, and one worthy the marked consideration he received from his colleagues in the United States. His recent visit to this country brought the matter more nearly home to every dentist, and forced investigation into the plan and modes of work. My interest began in it some two years ago, and at that time I endeavored to carry out his processes, as I then understood them. I reported the results to this Association, and at the same time stated that, while there appeared to be something in the force evolved in rotation, I had not been able to secure satisfactory density. Close observation of repeated clinics given by Dr. Herbst, during his visit in July and August of this year, forced me to the conclusion that I had not done the subject justice. The matter was at once taken up and continued at intervals to the present time. The results of these investigations I propose to lay before you this evening.

You will observe, as I proceed, that my object has not been so much to sustain the process, as taught by Dr. Herbst, as to endeavor to find out the practical value of rotation as a condensing force. The illustrations given by him demonstrated that the rapid revolution of a conical point was equal to the production of a density sufficient for all practical purposes; but this condensation was confined, in the estimation of the originator, to soft foils, or really to but one foil — Wolrab's gold. It seemed as though this was a very inconclusive result, when it is considered that this power, to be of any real value, must be capable of universal application, and be governed by a law which, however explained, must at least be so far understood as to be applicable in a general sense. The burnisher point as a condensing force is not, by any means, a new idea. The rounded, convex, or cone shaped surface was regarded at the period of exclusive soft foil as an important finishing instrument. It was recognized as a series of inclined planes, acting on the well-known screw principle, crowding the laminæ of foil together more perfectly than by direct action of the hand plugger. It was not, howevcr, applied to the rapid revolution of the engine until Dr. Herbst demonstrated its utility in this direction, and practically carried it farther than I have been able to reach with the same materials and the same mode of procedure. * *

Now if it be true -and I think it cannot successfully be denied —that the use of soft foil produced margins more satisfactory than cohesive foil, and that hand-pressure, while not overcoming altogether mobility to the extent obtained by the mallet, still preserved the cervical border from the attacks of acid better than the greater density obtained by power mallets, then it remains important that the cause should be discovered. That there must be a reason for it, not explained by the mere difference of foils, must be apparent to the most superficial observer. The same result was secured in the use of cohesive foil under hand-pressure. The introduction of the mallet blow was soon followed by complaints that the cervical border on approximal surfaces was almost certain to decay, and in proportion to the multiplication of force has this difficulty been augmented, until many have come to the conclusion that the saving of this border was among the very doubiful operations. That the best operators with the electric mallet have failed at this point, is a notorious fact. One of the most skillful in the use of the mallet remarked to me that others might be able to make a good filling at the necks of the bicuspids, but he could not, and he had resorted, in despair, to tin combined with gold. Others, equally skillful, have followed him with tin or amalgam, thus tacitly acknowledging that present modes are, to that extent, ineffective.

Is there any solution to this rather remarkable condition of things? We have had the fermentation theory and galvanic action brought forward to explain this, and while the former unquestionably has been demonstrated to have an important influence, the latter is still an open question, and both fail to explain the marked difference in results attained by the various modes in use during the past thirty-five years. The explanation must be looked for elsewhere, if it is to be found at all.

It is well known to all workers in the minute anatomy of dental tissues that the enamel is rarely free from cracks. These are not normal to the tissue, but have been produced by some occluding force, probably in the process of mastication, or it may be from the too sudden expansion and contraction caused by extremes of temperature. These cracks, by imbibition of fluids, predispose to the production of caries. This is so well understood that no intelligent writer can leave them out of the calculation of the causes of this pathological condition. The extent to which these exist in any tooth, in life, it is not possible to demonstrate histologically; neither is it possible to determine the character of the enamel border on any tooth during the operation of filling; but, reasoning from the recognized fact that cracks exist, we may fairly presume that they are present to a greater or less extent in all enamel, and that as they have unquestionably been produced by some sudden force their number may be multiplied by an increase of an equal force, or indefinitely in proportion to the power applied. This leads us directly to the question of force in its application to this process. As we have seen that the filling of gold, either soft or cohesive, by hand-pressure, resulted more satisfactorily in the preservation of this delicate border, the question assumes importance, whether the increase of force, by a sudden impact, has not been productive of fractures at that particular spot, more so than elsewhere, on account of the direct mallet action. Tin, tin and gold combined, and amalgam have each been found superior to gold impacted by force. The reasons for this result have not been satisfactorily stated. Tin has been supposed to be more in harmony with dentine—which is only another mode of expressing ignorance. Electrical action has been brought forward;

but the proof is wanting to maintain this hypothesis; in fact, we are left with the practical fact alone that they do preserve better than gold. Until something more suggestive offers, I claim that the explanation can be found in the fact that these materials are ordinarily placed in with hand-pressure, or no pressure at all, as in the case of amalgam. I am forced to the conclusion that the meaning of immunity from decay in the use of soft foil, tin, and amalgam is not so much in the adaptation to the walls of these materials as it is in the introduction and freedom from injury to the enamel at the border line. This opens, it appears to me, a wide field for investigation. Whether results commensurate with the importance of the subject be attained or not, it should certainly lead to reflection and a better and more thorough examination of the basic principles of practice in this direction.

If these views have a correct foundation, then a further consideration of reasons for rotation, as a condensing force, may be important. I say may be, for the time has not yet arrived, in my opinion, when any dogmatic assertions for or against can be tolerated. The process of rotation must be judged on its possibilities, rather than on what it has as yet accomplished. No process can be truly estimated, as to its merits, until it has run the gauntlet of years of critical observation. It comes to us however, at a period when the highest perfection, probably, possible has been reached with present modes; and it also comes to minds trained in the experience of all other forms of practice, and hence can be judged intelligently in the light of past experience—an experience that covers all forms of practice with all forms of material. As it has been seen, if my statement be accepted, that the use of hand-pressure with gold or other metals has been more uniformly successful in preserving teeth from caries than the more sudden force, it follows, I think, that any process that combines this advantage of hand-pressure with an almost equally great condensing power with the electric mallet must be of great value, if it be not the most perfect application of force yet devised.

The difficulty in the process, as originally explained and practiced by Dr. Herbst, lies in the fact, heretofore stated, that it confined the practice to very soft or so-called velvet foils. This seemed to condemn it as of no great practical value; nor could this statement be conceded without additional proof. Experiments with various foils quickly satisfied me that, with a slight change in manipulation, equally good or better work could be produced than with the velvet foils. It was observed that Dr. Herbst made use of broken excavator points, preferring the natural serrations of the crystalline structure to any artificially produced. He used this form of pressure to such an extent that the criticism was, I think, fairly made that he used two-thirds hand pressure to one of rotation. Whether this be true or not, the hand-pressure preceded the rotary movement, and that, in my judgment, with a very imperfect instrument. Acting upon this, I adopted the sharpest serrated points I could find—in fact, using the old, long, serrated instruments that fell largely into disuse after the introduction of power mallets. It is questionable whether the abandonment of these sharp points for very short ones, merely sufficient to roughen the gold, was not a mistake. Not a few have come to this conclusion. Be this as it may, the reason for objecting to them, of pitting the gold, has no force with rotation, for it must be evident that the constant burnishing of the surface will remove any pits left there by the serrations.

It is, I think, generally recognized as a fact that the property of cohesion cannot solely be relied upon. The conditions of the surface of gold are not always the same, and, if not universally up to the highest point of welding, an artificial substitute must be accepted. This, in rapid malleting, is accomplished by driving the laminæ of foil into each other, and does not necessarily require deep serrations. With hand-pressure it is quite different, and should be made strong, sharp and deep.

In the preparation of the cavity and in the selection of gold foil there need be no difference from that which ordinarily obtains. Good cohesive or non-cohesive gold foils may be used at the pleasure of the operator. I have used both; but as my experiments have been aimed to endeavor to employ cohesive with a rotary force, I have selected the former in the samples I present you. The plan I adopt is simply to pack with hand pressure—not being particular to go over the entire surface with the serrated instrument, but sufficiently so to insure adaptation to the part previously inserted; then with the steel, oval point (Herbst series) or what is much superior, the agate point, condense with some degree of force, going carefully over the surface. This operation is repeated until the cavity is full. It will be found impossible to produce even condensation by this means. There will remain depressions over the surface; but these constitute no serious objection, if they be not an advantage. They do, however, become a difficulty at the surface—or it is so with the present form of instruments. I have tried nearly flat surfaces with advantage; but they do not entirely overcome the pitting. My own judgment is that the last layers must be condensed by either hand or mallet force, using broad and short serrated instruments. *

Some present will remember that I presented in the *Dental Times* of October, 1871, the conclusions of some months of careful work on the relative value of mallet force. The fillings that were finally prepared by different operators were weighed by the United States Mint, at my request, and the result demonstrated that in proportion to the rapidity of the impact was mobility overcome, and that hand-pressure alone, on a moveable base, could not produce a density equal to the mallet blow, and that the ordinary mallet blow was unequal to the rapid blow of the electric. Hence a filling made by holding the tooth in the hand will necessarily lack density where hand-pressure is alone used. The time necessary to make similar and equally extended experiments with rotation has not been at my command, but the importance of a comparative examination of the relative value of the modes in use in condensing gold has not been lost sight of.

A number of fillings were prepared and weighed, but owing to the imperfection of the matrix used, were not regarded conclusive. As far as they went they demonstrated the probability of equalling the density of that produced by power mallets. I am not, however, convinced of the possibility of condensing gold by rotation to the extent of that obtained by the sudden impact of the mallet.* This is, in my judgment, not the most important feature of a filling. Close adaptation, and sufficient solidity to endure the wear of mastication, are the two important elements in success, and these must be accomplished without injury to the walls.

I have alluded to the possibility of fracture into microscopic cracks. This will, doubtless, be controverted by the assertion that no skillful operator will strike the wall. This may be true; but the fact nevertheless remains that the perfect operator has not yet been developed, and even if such were possible there would still remain the great mass of the careless or unskillful to work injury.

---

*Since the above was written I have prepared a filling of ⅛ oz. Abbey's No. 4 cohesive foil. This was made with great care, and was as solid as, I think, gold can be made by this process; but, while very dense, it did not seem to me equal in solidity to that made by the use of the mallet. It was subsequently rolled into plate by Mr. Abbey, and a portion beaten into foil.

Without specially advocating the rotary movement as superior to all other forms, it must be conceded in the light of experience, that adaptation to the walls can be made without the slightest danger of injury, and the union is almost perfect. * *

In reviewing the whole subject, I think the following points have been established: That a rotary force, applied as described, will condense any form of gold foil; that it is a safe mode to place in the hands of the most careless; that fracture of frail walls is impossible with it; that teeth ought to be preserved by its use, equally as with non-cohesive foil, tin, or amalgam. With so much in its favor, it is certainly worthy the attention of all operators. That the mallet will be abandoned is not to be expected nor desired. All modes have a value, and will live and serve a valuable purpose. * * * —*Cosmos.*

METAL WORK.

Read Before the Central Dental Association of Northern New Jersey.

BY DR. L. P. HASKELL, CHICAGO.

As everything depends upon the foundation being correct, when a metal plate is to be made be sure the impression is right. I do not deny that good impressions can in some cases be taken with wax, and more in modeling compound, but there are cases where neither is so reliable as plaster of paris. It may be accepted as an axiom, that the more difficult the case to secure an impression the more the necessity for the use of plaster. If one uses other materials, he must select the cases most favorable for each. I have found in a long practice that plaster being always reliable, and there being no tangible objection to its use, I secure the best results when I confine myself to it.

Believing that all that is necessary to secure successful results is to have the plate come in close contact with the membrane for adhesion, with a uniform pressure on the gums in mastication and correct articulation of the teeth, the only change I make in the plaster cast is to raise it with a thin film of wax over the hard places, and scrape slightly the rear, between the center and corner of the plate. In order to have the cast deliver itself from the mould, I make the sides flaring all around, that I may secure the best results. I use the only metal which has all the requisites for a dental die—non-shrinkage, hardness, toughness, smoothness, with a melting point of low temperature. These are found in Babbitt Metal, made from the proper formula, viz: one part copper, two antimony, eight tin, care being used to melt in the order named, so that the tin shall not oxidize. The counter die should be lead, with one-sixth of tin added, so as to reduce its melting temperature, lead melting at a higher temperature than the Babbitt Metal. Coat the die with whiting before pouring the lead. It is seldom necessary to make a second die.

The principal point to guard against is the center, at the rear; see that, by pumping the moisture from under it, it sets snugly enough to exclude air, but not bearing sufficiently hard to irritate and throw off the plate.

The margins of the plate should be carried as high as they can be worn all around, especially over the cuspids. The plate will hold better, and it must be carried high over the cuspids in order to restore the lost expression resulting from the extraction of those teeth; but it must be lowered just back of them to allow full play to the muscles.

The use of gum sections is inadmissible in my practice, because I cannot secure proper arrangement of the teeth nor of the gum, so as to restore the condition of the lips; neither can proper articulation of the the teeth be secured with them. Using plain teeth, then, we must use a rubber gum for attachment to the plate. I solder platinum loops to the plate to hold the rubber, fastening one end only.

As much depends upon a correct antagonism or occlusion of the teeth as upon the fit of the plate, and many cases are failures from a faulty antagonism when everything else is right.

The six anterior teeth should never meet. The pressure should be upon the bicuspids and first molar, and always be equal upon both sides. If there is a lower wisdom tooth (the first and second molars missing), it usually inclines forward, and should be avoided entirely, because if it meets the upper tooth at all it crowds the plate forward, constantly increasing the pressure as the jaws come closer together. If there remain upon the lower jaw the six anterior teeth and one or two bicuspids upon one side, and no teeth upon the other, the sooner they are removed the better for the interest of the patient, for the reason that the closure is one-sided and the plate is constantly displaced. The insertion of a partial lower set would not help matters, because very soon the artificial teeth would yield to pressure and be too short, and the uppers would meet only the natural bicuspids remaining.

The position taken by some dentists that the nátural teeth should be allowed to remain under all circumstances, is a mistaken policy, resulting in great discomfort to the patient in many cases.

A NEW TREATISE ON TEETH WITHOUT PLATES.

By H. C. MANSFIELD, D.D.S., Jefferson, Wis.

Among the new contrivances we have brought out, perhaps the most useful will be the tube of gold, platinum, or other metal, provided with a threaded pin with a slotted head, as a wood screw, to be placed primarily in the pulp chamber of doubtful dead teeth, either for temporary or permanent uses, the whole being enclosed with any kind of filling, the pin being removable with a fine screw driver if occasion require, the size inserted chosen according to circumstances, and large enough to admit the nozzle of a smaller syringe for injecting medicine to seat of trouble.

The tube principle will be the one adopted, we think, in adjusting the "teeth without plates." Every sound practitioner believes that artifical dentures should be removed occasionally, and one admitting this advantage must claim the preference, we think. This calls for greater manipulative skill, it is true, but good work, we are glad to say, is being again appreciated by many, and the extra pains required is well repaid in the important results achieved. The very name of gold strikes a responsive chord with many solid people, and when properly used in skillful hands, is productive of the greatest satisfaction. The rising generation of dentists should embrace every opportunity for instruction that comes, or rather it will have to be sought, but when obtained it will give lasting satisfaction and pleasure.

EDITORIAL.

FRANK W. SAGE, D. D. S., - - Editor.

CONVENTION NOTES.

The Mississippi Valley Dental Association seems to have gained a new lease on life, within the past two or three years. Five years ago it was whispered about that the old Association had about run its course, that it could not long survive the competition of the various state and local societies; that it must perish because it had reached the age of decrepitude, and stood merely as a landmark of a generation passed or rapidly passing away. To the writer it seems that there is no real reason why this old organization should not continue its existence indefinitely. If the infusion of new blood be deemed a constant requisite for maintaining an organization like this, what more happy combination of circumstances could favor that end than the appointment of time and place for holding the meetings of the old Mississippi Valley Dental Association? Once a year it invites the alumnus of the Ohio College of Dental Surgery to revisit the old lecture room, there to meet his classmates and renew his acquaintance with his *alma mater*. It is not improbable that the younger organizations of various states are indebted to the Mississippi Valley Dental Association for the influence she has exerted upon many young men who, as students, formed their first conception of what a dental association really is, while listening to discussions carried on under the roof of the Ohio Dental College. What other dental society comes to the very doors of the young graduate as does this Association, and calls his attention away from the confines of books and appliances to the higher education which comes from the interchange of views, theories and opinions? Who can estimate the influence this particular society has exerted in stimulating the ambition of *young* men just entering practice? But the Mississippi Valley Association is not going to die. True, we no longer see the familar faces of Goddard, Ullery, Osmond and Taylor, but we have still Harlan, Rawls, McKellops, Morrison, and others who have been or are coming into prominence. Let us unite in behalf of the Ohio Dental College to promote enduring interest in the old Association.

* * *

The dentist who never attends conventions denies himself the privilege of brotherhood in the profession. It may seem an unimportant matter to him,—the cultivation of fraternal relationship with others whom he meets only on these occasions. The resulting advantages become more apparent to him in later years, when he discovers upon consideration the difference in stature between himself and another who has identified himself with the body of those who meet at stated times for mutual improvement.

Nor are the rewards to be reaped by attendance at conventions so intangible as many profess to believe. The poet says:

> "The same good sense that makes a man excel,
> Still makes him doubt he e'er has written well."

So the dentist who is not too utterly complacent as regards his own acquirements and ability, is almost certain to go home from a dental convention with an idea or two which when practically applied benefits both his patients and himself. The very atmosphere of a convention prompts a man to self criticism, disabuses him of false preconceptions, and stimulates him to nobler effort. To some extent the same benefits may be derived from reading the reports of discussions, but not altogether. No report, even if verbatim, can stir the blood and thrill the nerves with the power of the speaker's actual presence. The fiery zeal and magnetism of a McKellops, the impassioned ardor of a Rawls, or the cool, logical precision of a Watt do not appear on the printed page. The secret of Harlan's popularity eludes the reporter's pen. But these are all of them features which having once been enjoyed in a convention will not readily be forgotten.

NEW OFFICERS OF THE MISSISSIPPI VALLEY ASSOCIATION OF DENTAL SURGEONS, Elected March, 1887.

President, A. W. Harlan, Chicago.
First Vice President, W. R. Morrison, St. Louis, Mo.
Second Vice-President, M. A. Fletcher, Cincinnati.
Recording Secretary, A. G. Rose, "
Corresponding Secretary, F. W. Sage, "
Treasurer, F. A. Hunter, "

COMMENCEMENT OF THE OHIO COLLEGE OF DENTAL SURGERY, CINCINNATI.

The forty-first annual commencement of this school was held Wednesday evening, March 2d, 1887, at College Hall, a large audience of ladies and gentlemen filling the hall to overflowing. Twenty-nine graduates, including one lady, received their diplomas. The dean of the faculty, Dr. H. A. Smith, conferred prizes upon students excelling in the following specified particulars: in the general examination, in mechanical dentistry, and in operative dentistry. The assignment of these prizes, and of another to be mentioned later, rested with committees of disinterested men not connected with the faculty. To Dr. L. E. Custer, of Ohio is accorded the extraordinary honor of having captured two gold medals for superiority under the first two heads above mentioned. Dr. Custer's penchant for prizes is phenomenal.

C. E. Miles, of Ohio, received a gold medal for superiority in operative dentistry. C. H. Doulton and E. J. McCartney received honorable mention.

Of the members of the Junior class, Henry Smith, son of the Dean, received a prize for the best general examination for admission to Senior class, W. E. Bryant and E. J. Ward being honorably mentioned.

Hon. H. P. Lloyd delivered an address to the graduates, which in point of appropriateness and tasteful discrimination, was much superior to many addresses we have heard on similar annual occasions.

At the conclusion of the exercises the faculty, students, and visitors repaired to the Hotel Emery, where, to the number of about one hundred, they partook of an elaborate banquet, furnished by the College *alumni*. The *menu* was as follows:

MENU.
Blue Points.
Consomme Napolitaine.
Filet of Salmon.—Sauce Ravigotte.
Potatoes Parisienne.
Relishes.
Sweetbread Pates a la Creme.
Sirloin of Beef—larded—Sauce Bernaise.
Punch.

Salmi of Wild Duck.
Head Lettuce.
Ice Cream and Assorted Cake.
Fruits.
Edam Cheese and Water Crackers.
Coffee.

At a late hour the assembly adjourned, after a most enjoyable time.

ILLINOIS STATE DENTAL SOCIETY. — The twenty-third annual meeting of the Illinois State Dental Society will be held at Jacksonville, beginning Tuesday, May 10th, and continuing four days.

A full programme of scientific work is arranged for, including a large and instructive clinic.

Dr. Black will give short lectures on micro-organisms, with practical illustrations of their culture.

All dentists will be cordially welcomed.

DR. J. W. WASSALL, Secretary.

◆

THE SWISS JEWELERS' BROACH, NO. 10. — I do wish to urge the utility of these in the treatment of root canals. These broaches are very delicate and easily entered into the finest canals, and are quite durable. The majority of teeth with dead pulps have very little matter within the canals requiring a barbed broach for its removal. The contents consist usually of broken down and softened tissue, which can be removed without incurring the risk of passing a barbed broach. He must have more nerve than I who will enter an ordinary root canal with a barbed broach.

My method of drawing the temper of the jewelers' broaches is to place a dozen in a tin box the size of the finger; fill with unslacked lime; heat the whole red-hot, and allow it to cool slowly. they are then to be polished with a pine stick, with pumice, on an Arkansas stone.—*Dr. J. H. McKellops.*

Made still better by drawing a separating file lengthways along their surfaces to groove and roughen them. — ED. *Items of Interest.*

MISCELLANY.

HYDRONAPHTHOL AND THE POTASSIO-MERCURIC IODIDE.

The following are the claims made for the newly discovered *Antiseptic*, Hydronaphthol, by R. J. Levis, M.D.

It is at least twelve times as effective as carbolic acid, and is entitled as a true antiseptic to occupy a position in the comparative tables next to the mercuric bichloride. It is thirty times as potent as salicylic acid, sixty times as effectual as boric acid, and has six hundred times the antiseptic power of alcohol.

Hydronaphthol is soluble when placed in cold water to the extent of one part in 1,100. It is soluble in hot water in the proportion of one to one hundred; but when the water becomes cooled to ordinary temperatures, a precipitate occurs, leaving a solution of one to one thousand. In this strength of one to one thousand it permanently prevents the development of the germs of putrefaction in all putrescible fluids.

Whilst the true antiseptic or inhibitory action of hydronaphthol in such cold aqueous saturated solution is perfect, its germicidal and proper disinfectant power is ineffective. For the destruction of already existing germs, such as have a tenacious vitality, as those of anthrax bacilli and pathogenic micrococci, it, therefore, can not be relied on. As to its action in this regard, as compared with carbolic acid, it should be remembered that a ten per cent. carbolic solution is required, a strength practically improper in wound treatment. In ordinary antiseptic practice carbolic acid is valuable only on account of its inhibitory action.

The first use of hydronaphthol as an antiseptic was by Dr. G. R. Fowler, of Brooklyn, to whom the profession is indebted for its introduction to practical surgery. It is a grayish substance in the form of crystalline lamina, having a slightly aromatic taste and odor. It is soluble freely in alcohol, ether, chloroform, glycerine, benzole, and the fixed oils. In the aqueous saturated solution of one to a thousand it is absolutely unirritating, and has no toxic action, either local or systemic; is free from unpleasant odor, and has no injurious action on metallic instruments or on cloth fabrics. Besides its use in aqueous solution, Dr. Levis has used it in the form of a powder, diluted, preferably, with the oxide of zinc in the proportion of one to fifty, and he believes that hydronaphthol may well displace carbolic acid from practical surgery.

The potassio-mercuric iodide is four or five times as powerful, as a true germicide or disinfectant, as the mercuric bichloride. For such use it is effective in aqueous solutions in the proportion of one to twelve thousand.

The potassio-mercuric iodide is made by simply dissolving equal quantities of the biniodide of mercury and the iodide of potassium in distilled water. The solution is evaporated and there remain yellow, needle-like crystals of the potassio-mercuric iodide.

In the use of such dilutions of this powerful antiseptic, local irritation is entirely avoided, and the risk of producing the constitutional effects of mercury is greatly diminished.

The introduction into dento-surgical threatment of these two remarkable and powerful substances, will do much to overcome some of the objections and inconveniences of antiseptic practice.

EUGENOL represents the strength of the essential oil of cloves. If its virtue comes from additional oxygen, as claimed by some, or mere exclusion of non-essential elements, I know not, but this I do know, it is good. I have used it to the exclusion of other agents in most cases for nearly three years, and with great satisfaction. No other agent has contributed so much to my success in the treatment of pulpless teeth. As a pain obtudent, by application to super-sensitive dentine, eugenol has the virtues multiplied of the time honored oil of cloves. This, with its disinfecting qualities and general innocence, gives it a value above any other agent with which I am acquainted for use in teeth containing living pulps.—*Dr. Newkirk.*

THERE are various ways of doing injustice and injury to our neighbors, even without charging them with incompetency or denouncing them as charlatans. A feigned look of astonishment when scrutinizing their work, a significant shrug of the shoulder, or a disapproving shake of the head, will have the effect of undoing confidence in the operations of their former dentists, and sometimes prove even more damaging than open denunciations. To ask if the doctor was not in a hurry when he filled their teeth, if the doctor himself performed the operations, if the work was not done by his student, if the doctor's eyesight is not failing him, etc., are insinuations that excite suspicion and convey the idea that operations have been slighted. Nor does it make things smoother to add in a semi apologetic manner that "the doctor was considered a pretty fair sort of a dentist once, but unfortunately he is getting old." This is needless and generally uncalled for. It inflicts injury on those to whom such references are made, and fills with distrust the minds of those who have received their attentions. And to sum up, no good whatever can result from such ungenerous criticisms.—*Facts.*

METHODS of practice which admit of an operation being completed at once, without reference to special after-care on the part of the patient, will continue to be most esteemed by dentists. It is small consolation to the dentist, when a failure has resulted as a consequence of a patient's carelessness, to feel justified in placing the blame on the patient. Fillings or artificial crowns which must be carefully avoided in eating, for hours, are not what the dentist, who wishes to avoid unnecessary annoyance, requires.

WE recently extracted a bicuspid tooth which had been extracted, filled, and replanted. It had done eight years' good service after being replanted. Its root was riddled and honeycombed by absorption, about two-thirds of it having been so removed. The patient, a lady, stated that pus had persistently oozed out from the gingival margins for a long time. The tooth was not apparently loose, and was extracted at the lady's urgent request, owing to the offensiveness of the discharge.

WE give no report of discussions of the Mississippi Valley Dental Association in this number of the JOURNAL, for the reason that much of the time was given to the consideration of appliances, and to subjects requiring black-board illustrations. A valuable paper by Dr. Harlan, describing the nature and uses of new remedies, will be given in a later issue.

IT is claimed that by the use of the galvanic current cocaine may be made to penetrate deeply into tissues, producing a more profound anæsthesia.

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. **Cincinnati, May, 1887.** **No. 8.**

MEDICAL DEPARTMENT.

THE CAREER OF WOMAN PHYSICIANS.

By JULIA W. CARPENTER, M.D.

It is often remarked by those unfamilar with the facts, that women physicians as a rule will not remain "life members" of the profession.

As opinions are without value when opposed to facts, some statistics on this point may not prove uninteresting.

The Woman's Medical College at Philadelphia had this spring its thirty-fifth annual commencement. It arose from small, earnest beginnings, and became one of the best colleges in the land. In 1881 the Dean of the College, wishing to know whether all the alumnæ were still practicing and how they were prospering, addressed a letter to each one. The number of graduates was then 276. About 175 or more have graduated since then, and if their record was added to this the proportion in all probability would not be changed.

The statistics gathered then were the first of their kind, and the facts collected then were woven together in the form of a "College Story." This was the commencement address of the Dean, and was afterwards published in pamphlet form.

The number of years covered by these statistics was thirty and the number of graduates, as before stated, 276. Of these, thirty-two had died. Several passed away after nearly thirty years' practice, and two, young and enthusiastic, went as medical missionaries to India and died of the fever of that country.

The first question asked was: "Are you now engaged in active medical practice?" Twenty-three replied in the negative. The reasons assigned were: domestic duties, 8; philanthropic work, 1; ill health, 6; retired, 3; no reason given, 5. These figures would doubtless compare favorably with corresponding ones from men's colleges, as many of their graduates are found in callings entirely outside of medical work.

As to the health and strength of women in busy professional life, facts give an unusually favorable account. In thirty years thirty-two deaths in 276 is not a large mortality rate. Some, too, were in a laborous country practice, as the following extract from the "College Story" will show:

"A young wife and mother practicing in Nebraska writes: 'During three weeks I did not have a night's unbroken rest. We had an unusually cold winter with deep snows, and I had hard work to attend to my countay practice. I was compelled to carry a shovel in my sleigh and shovel myself out when the snow got too deep.'"

Another started out years ago in a small village in Pensylvania, with a horse and saddle. She often rode ten miles at night as well as day. After her marriage if she had a call in the night her husband always drove for her.

Whether in city or country practice the health record so far is good.

As a special interest always seems to center around the married ones, some particular mention may be made of them.

Of the 276 graduates, 54 have married since graduating, and 75 were married women while students in the college. Of the 54 who married since, five have given up practice on that account, while many have achieved brilliant success since their marriage.

The combination of professional and domestic duties seems to surprise those who are not enough in the current to be familiar with the facts, but the instances are numerous and of long standing. Too many of these women are now in the field even to call them exceptional women. When a man with a family loses his wife, 'tis true he does not undertake to run his home, superintend his chileren and follow his profession too. But because a man does not do a thing, it does not follow that a woman cannot. As

St. Paul says, "there is diversity of gifts." Men and women always have done "impossible" things and always will.

Whether the statistics of other Women's Colleges would differ from these here given is not very probable, but the alumnæ of the Women's Medical College at Philadelphia certainly seem to be imbued with a love for their profession.

Their Alma Mater aimed high, as was shown by her being the first medical college in the United States, with the Women's Medical College in New York city, to adopt and require the three year's progressive course. The colleges for men gradually followed in their wake.

The statistics gathered and published in this "College Story." together with evidence from the graduates of other colleges, would seem to show that most women well educated in the profession, will continue life members of it.

ACCOUCHMENT DURING HYPNOTIC SLEEP.—Dr. Braun (*Wiener Med. Wochenshift*), reports a case in which he succeeded in rendering a woman unconscious during labor by throwing her into a condition of hypnotic sleep; The uterine contractions were particularly painful. They were equally violent during the period of unconsciousness, but the intervals were somewhat longer; dilatation of the passages took place in the most satisfactory manner, and delivery was speedily accomplished. The placenta was expelled into the vagina, and was easily withdrawn with the hand. On awakening, the patient did not complain of pain, and afterwards slept naturally for several hours. One of the most interesting features of the case was that the uterine contractions induced contraction of the abdominal muscles without awakening the patient. Hæmorrhage was very slight.

CORRECTION.—In Dr. Thompson's article on Multiple Epithelioma of the Gum, the recipe for boric acid wash should read:

℞. Acidi borici., ʒss.
Glycerinæ,
Aquæ dest., āā ℥ss.
M. ft. sol.

The acid would not dissolve in the ʒ. of liquid as given by printer's mistake in original article.

CHRONIC CYSTITIS.

By KONN B. SAYRES, M. D., Cincinnati.

It is said that the distinguished French surgeon, M. Ricord, when lecturing to his class upon a certain intractable disease, once stated that if he was ever doomed to eternal punishment hereafter, he expected to be interviewed at the very threshhold of pandemonium by his uncured patients, still suffering from the said disease, demanding, *viva voce*, a continuance of his treatment and a final cure; and that this reiterated din would constitute a part of his punishment.

If any such delegation should ever meet me at that same door over which Dante has written "Leave Hope behind all ye who enter here," I expect a certain number will be of those whom I have unsuccessfully treated for chronic inflammation of the bladder.

The space allotted for this article does not permit any consideration of the etiology or pathology of this affection, nor is it necessary to refer to the extent and variety of the lesions, symptomatic, systemic, idiopathic, and traumatic, which arrange themselves as causative of, or consequent upon, this condition of the urinary bladder.

The literature on the subject, though singularly lame and deficient in some respects, is sufficiently enriched by the writings of Roberts, Skene, Thompson, Gant, Tyson, Dickinson, Gross the elder, Gross the younger, Beale, Gouley, Harrison and others to give the inquiring mind a chance for investigation and comparison, aside from personal experience.

The writer must however, confess to serious embarrassment in the examination of this classical mass of genito-urinary literature, caused by the continual and unceasing reference to the "prostate" and its enlargement; the male urethra and stricture thereof; to gonorrhœa in the male and its extension to the bladder; to injuries from the use of the steel sound and cathetral traumatism, and to every other possible disease or injury of the "*male*" urinary tract.

In reading upon this sebject a person might naturally suppose that the viscus under consideration did not constitute a portion of the anatomy of the female.

Although this trouble is doubtless more frequent in the male, from causes sufficiently apparent, in the practice of the writer the large majority of cases have occurred among females.

This article is intended to give the history of one of these cases, with its treatment during a period of several months.

In August, 1885, I was called to see Mrs. A. a lady aged fifty-eight, married at twenty; husband living; two grown children; ceased menstruating twelve years previous. She was poorly nourished, and slightly affected with paralysis agitans.

She had been suffering for two years from a bladder trouble, which from history given seemed to have been developed shortly after the occurrence of a severe fall and severe shock thereby occasioned, with simultaneous exposure to fall of temperature while the body was perspiring. This history seemed to indicate a subacute inflammation of the bladder with very great urethral hyperesthesia. Her appetite, always very poor, failed more and more; her suffering was described as being extremely severe, micturition scanty and very frequent, the amount of mucus averaging from twenty-five to fifty per cent., which adhered to the bottom of the receptacle.

At the time I first saw her she seemed morbidly sensitive, apprehensive, and exceedingly nervous. Her urine was very scanty, mildly acid, one-third mucus, numerous leucocytes, and specific gravity of clear fluid 1008. The act of micturition was attended by agonizing pain, especially aggravated at and after time of the flow ceasing. This stoppage invariably occurred suddenly, with a spurt and violent cystic tenesmus.

Her bowels were very constipated, appetite lost, she was ingesting no fluids, and for a long time had failed to secure more than one hours sleep at a time.

From an impacted rectum I removed the fæcal debris, and caused the lower portion of the alimentary tract to be thoroughly washed out by copious and continued enemata, ordering minute doses of the mild chloride every two hours for several days.

Her bladder was carefully and thoroughly cleansed by means of cautious but persistent use of the double elastic catheter, and ordered

℞	Tr. ferri chloridi	gtt viij.;	
	Tr. nucis vomici	gtt iij.;	
	Tr. cantharides	gtt iv.;	
	Syrupus	ʒi.	Misce.

To be taken three times daily before meals in a small glass of water.

In passing, I desire to say that in fifteen years use of the above prescription in similar cases, where these nervous symptoms were well marked, I have never found it to fail in giving much relief.

I also ordered distilled water, one goblet full five times daily. She told me she could take medicine, but could not drink the water, as she "never had drank any." I think it a hard task to demand of the urinary organs a liberal evacuation from the bladder of a woman whose whole ingestion of fluids amounts to eight or ten ounces of "*tea*" in twenty-four hours.

However, in less than one week she was taking over forty ounces of distilled water, the urine was somewhat clearer and its specific gravity only 1003; its quantity much increased, and her pain less severe. Although her condition somewhat improved for a few weeks, the severe pain after micturition of a lancinating character, the cystic spasm, and anxious and peculiar expression of countenance awakened fear of malignant disease, and although there was nothing corroborative of this suspicion, discoverable by microscope or otherwise, I requested a consultation, and met a distinguished surgeon and gynæcologist of this city at her bedside.

The examination revealed nothing, but we felt able to assure the patient that her alarm concerning a malignant growth was unnecessary and unfounded.

At the suggestion of this esteemed gentleman she was put upon iron, quinia and balsam copaiba, and her bladder was washed out with solution of nitrate of silver one-eighth of a grain, increased to one-quarter of a grain to the ounce.

This resulted in developing almost instantly the worst case of capaiba pruritis I have ever seen, with the most intolerable and constant itching from head to foot, which threatened the reason of the unfortunate woman. She was given large doses of citrate of potash, bathed all over freely with alkaline solutions and given a jaborandi sweat. This relieved the urticaria or pruritis, and left her somewhat more comfortable.

The bladder symptoms still continuing, and no rest being secured at night, she was given

℞	Potassii brom.	āā ℈iv.;	
	Ammonnii brom.		
	Chloral hydratis		
	Morphia sulphatis	gr. j.;	
	Aqua dist.	℥i.;	
	Elixir curacoa	āā ℥ss.	
	Syr. aurantii cort.		Misce.

Signetur: dessertspoonful upon retiring.

The effect of this preparation was noticeable in securing her more rest at night; she continued, however, to get up every two or three hours and evacuate the bladder, and after each occasion enduring a season of agonizing burning and tenesmus.

The early part of November I began using suppositories of iodoform. These suppositories containing five to six grains of iodoform combined with coco-butter, about two and one-half inches long and of the calibre of a number eighteen sound, were slowly and cautiously passed through the urethra and entirely into the bladder soon after micturition and after the patient had retired for the night. This treatment gave great relief, the amount of mucus being much reduced, and upon one or two occasions during the subsequent two weeks the patient was disturbed at night only once, an experience she had not been privileged to enjoy, as she stated, for more than two years. After using these suppositories for some two weeks they seemed to lose their effect, and I combined with them cocaine and bismuth subnitrate, which for some weeks secured a fair amount of comfort.

During all this time the bladder was being washed out frequently with tepid water, and during the third week of the month of December the patient was feeling so much better, that her enthusiasm overcame her caution and judgment, and against medical advice and wishes of family, out onto the wintery streets she went to purchase Christmas presents. This egregious blunder resulted in a relapse of an alarming character, and an attack justifying the name of acute cystitis followed, with pus, bloody urine and great agony.

The field was resurveyed and gone over again, and January 1st, 1886, I commenced giving her the decoction of triticum repens and injecting her bladder twice daily with a weak decoction of the same from distilled water and carefully strained. The mode of injection was as follows:

I cut a large-sized Jaques catheter short, say to six or seven inches, inserted it carefully into the bladder. Then, using an elastic globe syringe, with a long and sharp nozzle, and guarded by a stop-cock, I was enabled to carefully throw in from one to four ounces of the injecting fluid, having it perfectly under control so that at a moment's notice, in the event of tenesmus, pressure being removed from the bulb of the syringe, the fluid could in part return to it.

In a short time the amount injected was increased a dram at a time until the bladder would receive, when thrown in slowly, six ounces, thus securing fair expansion of the rugæ and thorough cleansing,—the bladder being injected twice at each visit. I neglected to mention that at the commencement of these injections after the relapse, I used, previous to the injection of the triticum, a two per cent. solation of cocaine hydrochlorate, of which one-half ounce was used twice daily. The patient was placed upon generous diet as far as her appetite would accept it; the condition of her bowels carefully watched, and, occasionally, the hypnotic previously noticed was given at the retiring hour.

She steadily improved, occasionally using a suppository of iodoform and cocaine, and in February I threw into her bladder a solution of iodoform and starch in water and glycerine, once a day.

The amount of mucus in the urine on March 1st was less than five per cent., her general health was perceptibly better, and the specific gravity of the fluid had come up to 1,019. I should also have said that early in January her urethra was freely dilated to the dimensions of the little finger and its mucous membrane thoroughly touched with nitrate of silver, which, after a few days, resulted in a great reduction of pain upon micturition.

During the late spring of 1886 the patient very much improved in general health, enjoying a fair amount of rest at night; seldom disturbed for micturition during the night, decided to pay a visit to some relatives and passed out of my care, and has not, so I am informed, been under any medical treatment since. Her husband informs me recently that, although she is not entirely well, she is so comfortable as to be able to avoid the ordeal of treatment, seldom suffers pain, and is blessed with sufficient sleep, not being disturbed more than once at night, and often going the whole night through without rising to empty the bladder.

Surely, in comparison with her wretched condition of August 1875, which I so well remember, her present state is so much better as to justify any amount of speculation and experiment in the handling of her case.

No. 70 West Seventh Street,
May 9th, 1887.

THE RELATION OF THE DISEASED NASAL MUCOUS MEMBRANE TO ASTHMA.—Dr. Böcker, of Berlin, summarizes his observations as follows: 1. Reflexes can be originated from every part of the nose. 2. The reflex action of the mucous membrane is independent of the corpora cavernosa (Hack). 3. The destruction of the corpora cavernosa does not arrest the reflexes. 4. The swelling of the lower turbinated body is physiological. 5. The reflex-arresting-power of large polyps does not exist. 6. Asthma is seldom associated with nasal polyps. 7. Asthma can be originated under certain circumstances by all mucous membranes. 8. Asthma is usually produced by the bronchial mucous membrane. 9. Odors and psychical impressions can produce asthma. 10. Normally, asthma cannot be produced by the nose. 11. Trigeminus-asthma is caused by morbid states of the nervous system. 12. The impossibility of respiring nasally may produce asthma. 13. Asthma occurring from "catching cold" is originated by swelling of the bronchial mucous membrane. 14. Hay-fever asthma is produced by direct irritation of the bronchi. 15. Cavernous tumors, papillary growths and adenoid vegetations often produce nightmare. 16. Asthma is often independent of nasal conditions. 17. The treatment of nasal affections can sometimes cure asthma. 18. Extended galvano-caustic operations on the nose are to be avoided. 19. Radical cure of asthma is seldom effected by mere removal of nasal polyps. 20. In the treatment of asthma, constitutional treatment is of the greatest importance.—*The Journal of Laryngology and Rhinology*, January, 1887.—*N. Y. Medical Record.*

EDITORIAL.

A. B. THRASHER, A.M., M.D., Editor.

THE NEW CINCINNATI HOSPITAL STAFF.

Our editorial (or something else) has at length stirred the Trustees of the Cincinnati Hospital to make some changes in the staff. The change will not lessen the efficiency of the staff and will add materially to the harmony of the rival faculties.

The new appointments are: Prof. Ransohoff, Surgeon; Prof. Forchheimer, Physician; Prof. Reamy and Prof. Palmer, Obstetricians,—all from the Ohio Medical College.

The complexion of the staff now is as follows: Eight Miami men, six Ohio, and two neutral.

There can be no question in regard to the fitness of the new members for the position. They are gentlemen of more than local reputation in their respective specialties. They are all fluent speakers who are accustomed to lecture before large classes of medical students. They are gentlemen who write and whose writings are read at home and abroad. They will know how to utilize the large clinical material of this hospital and make it take a more prominent place as an educational factor.

We heartily congratulate the Trustees on the wisdom of their action; and the newly appointed members of the staff on the increased facilities they will now have in the use of the clinical material of the best appointed hospital in the West.

IMPURITIES IN ICE.—It has long been known that pure drinking water is of the greatest sanitary importance. It is, however, pretty generally believed that the crystalizing process in freezing completely purifies the water, and that we may safely use ice from a pond when we would not think of getting our drinking water from the same source.

To a limited extent this commonly held opinion is true, but the investigations recently made by Dr. T. Mitchell Prudden, of New York, show us that all ice is by no means free from active and harmful bacteria.

Ice is so universally used in drinking water that impurities in it become a source of very considerable interest to us as physicians. Dr. Prudden has observed that in "snow-ice" and ice full of air bubbles more bacteria are to be found, but when clear it is comparatively harmless. He suggests, however, that for drinking purposes only ice made from distilled water should be used. Since this cannot always be had, we would suggest as an amendment "or made from water pure enough for table use."

THE DARBY CONTEMPT CASE. — The Lebanon Circuit Court has affirmed the judgment of the Common Pleas Court in fining Dr. Darby for contempt of court in refusing to testify in the Green murder case unless granted expert fees for expert testimony.

The lawyers all stand together in this matter of refusing to recognize a physician's professional knowledge as his personal property. If the court orders a lawyer to do anything it is understood that he gets a good, round fee, but it is all right for a doctor to do something for nothing.

We hope the profession of the State will stand by Dr. Darby in taking this case to the Superior Court.

ANALIN OIL IN PHTHISIS.—Dr. Kremjanski, at the Congress of Russian Physicians held at Moscow last January, advanced the idea of curing phthisis by inhalations of atomized analin oil. His theory is that the remedy is thus brought into direct contact with the tubercle bacilli, which is destroyed without injury to the patient. He reported two cases illustrating his method of treatment and the Congress appointed a commission to investigate the results.

Dr. Nesteroff tried the remedy according to Kremjanski's plan and the patient became rapidly worse and died in a short time. The case was reported to the Moscow Medical Society, where there was almost a unanimous opinion that the treatment would not only prove useless but even dangerous.

Who will discover the next?

ABSTRACTS.

RHEUMATIC CEREBRO-SPINAL INFLAMMATION.

By J. BROWN SIM, M.D., L.R.C.S., Edin.

The following case presents many points of interest, as the supervention of grave changes in the cerebro-spinal system are not commonly met with in the course of a rheumatic affection. In this case that disease could never have gone beyond the subacute stage; and beyond the suspicion that the mental faculties had not for some time been quite so sharp as they previously had been, there was no apparent cause why symptoms of so serious and grave a character should have been set up. It possesses many features of resemblance to the case of disseminated myelitis reported in THE LANCET of Nov. 13th of last year, as having been brought before the Royal Medical and Chirurgical Society by Dr. Thomas Barlow, where symptoms of a somewhat similar character had occurred during an attack of measles; and it will serve to point out that the liability to the occurrence of such complications is not confined to the acute specific fevers. Without attempting any explanation of them, I will proceed to give the clinical notes, only drawing attention to the transient character of the first paraplegic attacks, and the subsequent rapid progress of the disease to a fatal termination. I have to express my obligation to Dr. Ransom for his kindness in supplying me with the early notes of the case.

H. S. M——, aged seventeen, occupied as a clerk in a counting-house, first consulted Dr. Ransom, of Nottingham, on October 30th 1886, complaining of his left knee-joint being enlarged, and of a swelling on the dorsum of the left hand. On inquiry it was found that the patient's father had had several attacks of rheumatic fever, and frequently the same malady in a subacute form. In other respects the family history was a good one. The patient had about a year before an illness accompanied with pain and swelling of the left knee-joint, which continued for some weeks, but did not lay him up in bed, and from which he completely recovered. For a month previous to his visit to Dr. Ransom the patient had a swelling on the dorsum of his left hand. This had become much reduced in size, but at the time of his visit it was readily felt as a firm substance about the size of half a nutmeg, and apparently deeply placed near the bone. It had been painful, but was not then so. A week previously the left knee-joint again swelled, and was slightly painful and tender. Dr. Ransom detected fluid in this joint. There was also some pain in the back and head. But he did not appear to be feverish, or to suffer much general malaise. Treatment consisted of salicine and iodide of potassium. On Nov. 8th the patient again visited Dr. Ransom, who noted that the symptoms were a trifle better all round. On Nov. 13th the father called on Dr. Ransom and reported that on afternoon of the 11th his son had suddenly lost the power of moving his legs, and had remained in this state for about a quarter of an hour; that he then recovered, and walked upstairs. That again, about two hours previous to his call on Dr. Ransom, a similar temporary loss of power had come on and passed away. The same afternoon the patient was seen at his own home by Dr. Ransom and myself. He was in bed, and was noted to be thin, pale, and overgrown for his age. It was found that he had completely recovered the use of his legs, and that sensation was normal, as evidenced by his being able readily to localize a pinch or a light touch. The swellings on the hand and knee had almost completely disappeared. On asking the patient to describe the seizure on the 11th, he had at first no recollection of it. On being reminded by his mother, he was then able to recall and give a fairly connected account of it. He described the attack as coming on gradually, beginning with a feeling of numbness in his legs, and passing on to entire inability to move them. He thought it would be quite fifteen minutes in reaching this stage. There was also partial but very slight loss of power in both arms. Since this seizure he was noticed to have some difficulty in passing urine, and to fail in obtaining much relief after doing so. The second attack of paralysis was described as similar to the first, but only affecting the legs, and did not last long. He had not much pain, but complained of some over the region of the stomach. Examination of the spine failed to show any tenderness. The heart and lungs were both normal. The bladder contained a good deal of urine. The mental faculties were clouded, the patient often requiring to be helped out with his facts by his friends. He was stated to have been a bright, lively, intelligent boy, but his father thought him to have been less so for some months past.

Nov. 14th.—10 A.M.: Patient's mind appears to be more hazy this morning. He states that he has had a good night, and has no pain except in his abdomen, which he refers now to the hypogastric and now to the left hypochondriac regions. His memory is worse, as shown by his not remembering that two doctors had been to see him the previous evening. His friends state that he appeared to suffer acutely for four hours during the night, but this he had no recollection of himself. After this attack of pain he appeared to become hot and feverish. He forgets what month it is, and though he made inquiry as to what the thermometer was for when it was put into his axilla, yet he had no recollection of having seen it when it was taken out again. He had also an illusion that there was a clock on the wall. Patient had passed thirty-one ounces of urine during the night, but as his bladder still seemed distended a catheter was passed and thirty-one ounces withdrawn. On examination afterwards the urine was found quite free from albumen. Temperature 100·2°; pulse 114. At 4 P.M. I was summoned to see him, as he had become very violent. He was struggling so much that it was with difficulty he could be kept in bed, and he answered questions very incoherently. Temperature 100·2°.

15th.—10 A.M.: Patient had slept one hour and three-quarters after a sedative prescribed at the last visit, but since then he has been very restless, biting his upper lip, which was cut and much swollen in consequence. He has been passing urine in bed. Temperature 99·8°; pulse 124. Catheter passed and thirty-four ounces of urine withdrawn.—7.30 P.M.: Patient has passed a quiet day, taking liquid nourishment moderately well, but remaining unconscious. He has not been noticed to move his legs to-day. Tickling or pinching them makes no impression. He moves his arms freely, but with this exception he remains in the position he is placed in till he is moved into a fresh one. There has been no urine passed during the day. Twenty-three ounces withdrawn by the catheter. Temerature 98·4°; pulse 126.

16th.—10 A.M.: Patient has passed a quiet night, but was never conscious. He has taken a moderate quantity of milk and beef-tea. Coma this morning is not so profound, as he replies on being asked a question in a loud sharp tone, but could not recognize his friends. No urine passed during the night; thirty-one ounces withdrawn by the catheter. Temperature 102°; pulse 108. —7.30 P.M.: Patient has been comatose all day, only occasionly replying to a question; but has taken more nourishment. He has not been observed to move his legs at all to-day, though it has been specially watched for. He has been perspiring freely, and has been frequently belching. The urine is still retained; twenty-four ounces withdrawn by the catheter. Temperature 103°; pulse rapid, but difficult to count, as he is constantly moving his arm about.

From this time the coma rapidly became more profound, death taking place about 11 A.M. on the 17th, nearly six days from the time he had his first attack of paraplegia. No post-mortem was obtained.—*The Lancet.*

NEURASTHENIA.—Among the cerebral symptoms of neurasthenia none is more conspicuous and constant than headache. Many instances of so-called sick headache are of a neurasthenic origin. Of greater significance is a peculiar distressing sensation of the head, which patients compare to the feeling experienced when some heavy body is pressed on the vertex. The scalp in neurasthenia is exceedingly sensitive to the touch so that the use of the comb and brush cause pain. Disorders of the special senses are very common, consisting of flickering before the eyes, muscæ volutantes, asthenopia, noises in the ears, a perverted smell and a sour pasty taste in the mouth. Sleep is much disturbed by terrifying dreams. Many patients declare they pass vigilant nights for weeks.

The physical symptoms of neurasthenia usually partake of a depressing character. Sometimes they amount to utter despondency or melancholy. More frequently the mental irritatability shows itself in curt answers, in exhibitions of a morose and peevish temper and not seldom in a disagreeable selfishness. Probably the desire of subduing or chasing away the moods and vapors of which the patients themselves are conscious, is one of the causes that frequently leads them to resort to alcoholic stimulants and narcotics. When such patients fall into the habit of reflecting much on their unpleasant feelings they are sure to become confirmed hypochondriacs.

Morbid fears constitute another set of symptoms which occasionally plague the neurasthenic.

An enormous array of symptoms is attributed to the spinal form of neurasthenia. There are few neurasthenic patients who do not suffer from eccentric neuralgic pains and muscular weakness of the lower extremities. Real paralysis does not occur, but there is a constant feeling of fatigue and a desire for rest. Lumbar or sacral pains seem never to be absent. The general sensibility is heightened. Slight pressure of superficial nerves causes tingling; the contact of cold substances produces pain. There is a sensation of burning in the palms of the hand and soles of the feet. Neurasthenic females complain that their shoes press too tightly, and their dresses make them feel uncomfortable, all of which is provoking to trades-people, who despair to please their customers. The reflex excitability is augmented. Micturition and defecation may in consequence be attended with much discomfort. Muscular hyperæsthesia causes twitching of muscles and painful movement of the joints. Paræsthetic symptoms are felt everywhere, consisting of numbness and the sensations of pricking and formication. Vaso-motor disturbances bring on fitful flushings of the face and partial sweatings. The respiratory symptoms are sometimes of an alarming character, consisting of embarrassed breathing and a choking sensation attended by a tumultous action of the heart. The gastric disturbance witnessed in neurasthenia constitutes the so-called "nervous dyspepsia," which is common in over-worked clerks and seamstresses, and no less also among people in different walks of life that impose varied hardship and deprivation of the required rest and sleep. Such a dyspepsia baffles the usual remedies, unless a change of habits and pursuits be adopted.

It is hardly necessary to state that the diagnosis of neurasthenia should not be lightly made. Chronic and progressive diseases in their early stages often give no other intimation of their existence than the evidences of a declining state of the general health. The nervous depression, which is then surely to ensue, is liable to lend a neurotic feature to the ill-defined symptoms depending on the undeveloped disease, and the more so, if the patient is constitutionally predisposed to nervous affections. On the other side there is a risk to mistake neurosthenic symptoms for serious organic trouble. The experienced physician will find no great difficulty to distinguish neurasthenia from allied nervous disorders, though it must be confessed that the pictures presented by this class of maladies are so frequently confusing by their variegated coloring, or so frequently change into dissolving views, that their distinction often turns upon the choice of a phrase.

There is great scope for the display of tact and judgment in the treatment of neurasthenia. The physician would do well to take the patient into his confidence should there exist the least reason to believe that preventable etiological factors are at work; which on being abandoned or removed will materially assist. The patient may either require absolute rest and quiet, or be benefitted by exercise that does not fatigue. The recuperative influence of mountain air or a visit to the sea shore may, under circumstances, be indispensable. Dr. Beard says he has seldom found general anæmia associated with neurasthenia. My experience induces me to differ from him. A judicious course of tonic remedies is often of great value in long standing cases. For the restoration of muscular vigor, as Dr. Beard has indicated, nothing can surpass the refreshing effects of general faradization. After a number of trials with various remedies which stand in repute for the relief of nervous headache, I give now the preference in the neurasthenic variety to a combination of ether and the tincture of cannabis indica, in doses of twenty drops of the former and ten of the latter. Sometimes these remedies act better after a goood night's rest has been obtained from a full dose of chloral hydrate. Great caution is necessary in the administration of opium or any of its alkaloids, for fear of inducing a disastrous habit, to which neurasthenic patients are particularly inclined. The practice of giving now large and repeated doses of the bromides is open to much less objection. In regard to arsenic, phosphorous and the salts of copper and zinc, which are empirically ordered in neurotic affections, I cannot say anything of a positive character concerning their employment in the treatment of neurasthenia.—Dr. Arnold, *Baltimore Academy of Medicine.*

ON SOME OF THE THERAPEUTIC USES OF ALCOHOL. — By Austin Flint, M.D., LL.D., of New York.

In certain pathological conditions, a moderate and sometimes a large quantity of alcohol may be administered without producing any appreciable excitement, much less evidences of alcoholic intoxication. Notwithstanding this the alcohol has a certain effect, although this effect is quite different from that produced when it excites or intoxicates and when it exists as alcohol in the circulating fluid.

It is with regard to this second effect of alcohol, unattended with what may be called its toxic manifestations, that I propose to present certain physiological and clinical reflections.

In pathological conditions chiefly in acute diseases, in which alcohol is useful, it acts as a representative of the hydrocarbons, in a form in which it is readily absorbed and oxidized, requiring no preparation by digestion. In this way the hydrocarbons may be introduced when the digestive function is impaired, in a form which may be compared to the condition of peptonized, nitrogenized elements of food. In its action, under these conditions, it is a hydrocarbonaceous food, promptly oxidized and not circulating as alcohol in the blood.

If it can logically be assumed that a part even of the hydrocarbons is changed into alcohol and is oxidized in nutrition, there can be no moral objection to the judicious administration of alcohol in therapeutics, any more than to the administration of sugar and starches.

The advantages of the careful administaation of alcohol in certain cases and in certain stages of fever have long been recognized and admitted on the basis of clinical experience.

In two cases of diabetes of long standing, now under my care, in which a cure cannot be effeted, the object of treatment being to produce a tolerance of the disease, I have given, in small doses, a quantity of whiskey exactly equal to the weight of sugar discharged daily. In one of the cases, in which I have been able to follow the changes in temperature, the temperature under the tongue was 97¼° F. on December 15th, 1886. After taking four ounces of whiskey daily, for eight days, the temperature, on December 23d, was 98° F. I shall employ this treatment in other cases in which the glycosuria cannot be arrested, in the hope that the supply of alcohol to compensate the discharge of sugar may bring the temperature of the body to the normal standard, and contribute to the tolerance of the disease.—*Med. Register.*

THE USE OF ANTIPYRINE FOR FEBRILE CONDITIONS DURING DENTITION.—The usefulness of antipyrine in infantile therapeutics is daily becoming greater, and it now constitutes on of the most desirable acquisitions of modern therapeutics. Its particular value in broncho-pulmonary diseases of a febrile character is a matter of daily demonstration, and by its use we are enabled to obtain the most satisfactory results in diseases of a similar character which have hitherto furnished the most sombre picture in infantile pathology. In addition to the usefulness which has been referred to, the author has found it to be of great advantage in the febrile conditions which commonly accompany the evolution of the teeth. Not only is antipyretic effect exerted in cases of this character, but it also has a perceptible sedative effect upon the nervous system. It may be given to a teething child in doses of eighty centigrammes per day, the dose being repeated until the fever and other symptoms have disappeared. If the stomach is sensitive, it is desirable to give the drug through the rectum.—*Jour. Pediatrics.*

A New Procedure for the Removal of Small Calculi from the Bladder in Male Children.—Mr. Thomas Annandale reports the following operation upon a boy of four and one-half years, the subject of a small stone. Under chloroform the urethra was dilated, the bladder injected with antiseptic fluid, a small lithotrite passed and the stone seized. The handle of the instrument was then depressed, causing its vesical extremity, together with the stone, to be felt through the abdominal wall immediately above the pubes. A small incision was then made which allowed the lithotrite to be pushed through the wound, the stone was extracted and a No. 9 india-rubber catheter was seized and drawn into the bladder as the lithotrite was withdrawn. A tube was inserted through the abdominal wound. After forty-eight hours both tube and catheter were removed, and the patient was well on the tenth day.

Mr. Annandale believes this to be a much less serious proceeding than the ordinary suprapubic operation, as the bladder is scarcely disturbed and the wound made in it is very limited.—*British Med. Jour.*

Pregnancy Complicated With Ovarian Tumors; Tapping, Delivery, and Subsequent Removal of Cysts.—By H. F. Bailey, M.R.C.S., L.S.A.

On June 5th last I was called to a lady, aged twenty-nine, whom I was to attend in her first confinement. This was about a fortnight before term. I found the abdomen excessively large, and both legs œdematous, blue, and mottled. Palpation revealed fluctuation with distinct thrill, and percussion resonant flanks, with dulness over the rest of the abdomen.

The diagnosis was left ovarian cyst, and, as the tumor was very tense and the patient evidently in imminent danger from rupture of cyst, I tapped about two inches above the umbilicus and removed about two gallons of ovarian fluid. Five days later labor came on, and with forceps a healthy female child was born. Lactation was permitted for three mouths, but the tumor again filling rapidily, the child was weaned.

On Sept. 14 I operated, aided by my partner, Dr. J. N. Miller, Mr. Cooper giving methylene. On opening the abdomen by a four-inch incision, not only was there the left cyst as diagnosed, but the right ovary was the seat of a second tumor, a very dense-walled dermoid cyst weighing 2 lb. I removed the left cyst in the usual way, tying the pedicle by transfixion with Chinese twist and returning it. The tumor of the right ovary was next removed in like manner, and its pedicle also returned. Only one adhesion of omentum required ligature and division. After thorough sponging of the cavity, the incision was closed with silk sutures passing through the whole thickness of the abdominal wall, a Keith's tube inserted, and the wound dusted with iodoform and dressed with Gamgee pads and strapping. The tube was emptied of colored serum every six or eight hours for a couple of days, and then removed. The dermoid cyst contained epithelial matter and much hair, the whole mass having the appearance and consistence of mortar; the cysts and contents weighed over 26 lb. Recovery was uninterrupted; the evening temperature on the day of operation was 100°; pulse 88. The next day the pulse and temperature were normal, and remained so. * * * — *The Lancet.*

EXISTENCE OF THE CANAL OF PETIT QUESTIONED.—M. Claeys has communicated to the Royal Academy of Medicine of Belgium an account of some elaborate researches he has been making, with the help of all the most improved methods of microscopical manipulation, on the anatomy of the eye, and especially on the construction and attachments of the ciliary ligament. The canal of Petit, he believes, does not exist.—*The Lancet*, Jan. 1887.

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, May, 1887. No. 8.

DENTAL DEPARTMENT.

IRREGULARITIES OF THE TEETH.

Synopsis of a Paper read before the Mississippi Valley Dental Association.

By G. W. Keely, D.D.S.

Without fear of successful contradiction, we assert that the premature loss of cuspids and molars, especially of the temporary set, will invariably result in a crowded condition of the permanent teeth. The permanent incisors when first erupted, are often crowded. Losing sight of the fact that the arch is enlarging, an erroneous conception may arise that it is necessary to extract the cuspids (temporary) to make room for the crowded permanent incisors. The effect of this procedure would be to correct the irregularity, but in the near future a far greater evil would arise, viz.: the first permanent bicuspid (which usually erupts two or three years before the permanent cuspid) would erupt prematurely, occupying the space which belongs properly to the permanent cuspid, leaving no room for the latter excepting outside of the arch. The fact should be be kept prominently in mind that the permanent cuspids play a conspicuous part in preserving the contour and beauty of the face. Sometimes the unpardonable sin is committed of extracting these permanent cuspids, thereby destroying the contour of the face beyond possible restoration.

[Dr. Keely explained that in some cases presenting where the bicuspids are found in contact with the lateral incisors,—the permanent cuspids being thus forced to erupt out of line—it is possible to expand both arches sufficiently to make room for the cuspids, but the operation consumes so much time and involves so much pain and inconvenience to the patient, that the lesson he was seeking to impress, of avoiding mistakes in early extraction, was very forcibly presented by those very facts.]

In one case of the above description he extracted the first bicuspids, expanded the second bicuspids, at the same time starting the cuspids back, and when this was partly accomplished, inserted a retaining plate to hold the bicuspids in place. Nature, with the assistance of constant pushing by the patient with her fingers upon the cuspids, effected a harmonious arrangement in about two years.

The great importance of retaining the temporary molars long enough to prevent the first permanent molars from crowding forward and encroaching upon the space belonging to the permanent bicuspids, should be kept in mind. Treat such temporary molars, if no more can be accomplished than to save the roots for a time.

[Casts were exhibited, showing the second bicuspids erupted out of the line, in consequence of a premature extraction of the temporary molars, allowing the permanent molars to press forward. At the same time the permanent incisors had become widely separated for lack of support from behind.]

The roots of pulpless temporary teeth are never absorbed, but will turn aside, out of the arch, the permanent successor. The timely removal of such pulpless teeth should be attended to. Permanent incisors erupting inside the temporary incisors, will usually assume a normal position after the extraction of the latter. If in danger of becoming improperly locked inside the opposing teeth, instruct the patient to press them out with the thumb or by using a soft wood wedge.

What shall we do with badly demoralized first permanent molars? I will say in passing that I have never seen a case where I regarded the removal of sound, healthy first molars indicated. I never saw a case where I thought the removal of the cuspids was indicated, nor do I expect ever to see such a case. But as regards the first permanent molars, when I find one or more badly broken down, with a pulp exposed or dead, and the patient ***under twelve years of age***, the case is quite different. They should be removed, even when there is no appearance of a crowded condition. If this is done prior to the eruption of the second molar, the latter will come forward bodily, without the slightest indication of tilting, and stand squarely up against the second bicuspid. The earlier eruption of the third molar will result, and it will be as good and as perfectly developed as its neighbors. These third molars are always good when they have ample space to erupt.

Dr. Keely cited a case of a Miss aged twelve. The first inferior molars were abscessed, while their upper antagonists could have been filled. The upper cuspids were outside of the arch and above the line of the laterals and bicuspids. To make room for forcing the bicuspids back, in order to allow the cuspids to come down into line, the upper first molars were sacrificed with the lower. Nothing further was done (after having forced the bicuspids back by wedging, thus accomodating the cuspids) but to insert a thin vulcanite place, bearing hard on the superior bicuspids, in order to expand them a trifle in order to complete their perfect antagonism. Within two years Nature effected a perfect arrangement and articulation of all the remaining teeth.

In other cases, of which models were shown, where the anterior teeth were crowded, laterals twisted, and similar deformities existed, great improvement had resulted from simply extracting the first permanent molars, as indicated by the requirements of the cases.

◆

USE YOUR MAGNIFIER.

The value of a good magnifying lens on the operator's tray is best appreciated by those who have used them. It has been asserted that the imperfections at the margins of cavities and at the edges of fillings, as disclosed by a magnifier of low power, are as nothing compared with what the microscope would reveal in the same cases, and that these imperfections are beyond the power of the most skillful to remedy. It is nevertheless true that an ordinary lens shows imperfections such as may be avoided or remedied within a range of limitations contributing to a practical avoidance of failure for a long time. Many a slight exposure of a pulp which escapes the closest scrutiny of the unaided eye becomes plainly apparent when a lens is employed. Many an apparently perfect edge of enamel shows disintegration or fracture, which is recognized as the sure precursor of failure of a filling. A good lens costs only a trifle and is almost invaluable.—[ED.]

NEW REMEDIES.

By A. W. HARLAN, M. D., D. D. S., Chicago.

There have been a number of drugs brought to our notice during the past few years, some of which have already been adopted in the daily practice of many dentists. Very often dentists, like doctors, read of the supposed wonders that a new drug will accomplish and pass it by for the time being, expecting to use it when occasion offers. This may not be for a long time if the drug is not easily obtainable, is high priced or its properties not well understood. If we look back for only a short period it will be noticed that as long as cocaine was scarce, there was a steady demand for it, but now I fancy there are many dentists who after their curiosity was satisfied have ceased using it. It does not follow that something better has supplanted it; they were disappointed in its use because it would not act uniformly in all cases. For a variety of reasons, either the drug was impure, lacked potency, or was improperly exhibited; at any rate it would not obtund sensibility in dentine, and there was the place where it was most needed. Cocaine then and now is of value, but it has not a wide range of usefulness in the daily practice of dentistry. The novelty has worn off and it is finding its legitimate place as a local anæsthetic for the soft tissues.

The newer remedies are *iodol*, *aseptol*, *eulyptol* and *trichlorphenol*. Of the first, if it was intended to supplant iodoform; it has one virtue in not being nauseous to smell. I have used it, combined with pure tereben to paint the edges of ragged gums, as a dressing after the removal of necrosed bone, and have packed it into pockets around teeth to check the production of pus. In all such cases it may be substituted for iodoform. In combination with oil of wintergreen, packed into foul smelling roots it acts with certainty, destroying the odor and rendering them aseptic in from three to five days. It is useful in teeth with exposed pulps, causing no pain, but very quickly subduing it.

It may be packed into indurated folds of the gums or mucous membrane, and after a short period such tissues become less rigid and regain their normal sensibility and mobility. Aseptol or sogolic acid is an oily liquid with an acid reaction, soluble in water and other menstrua, and is a powerful germicide and disinfectant.

I have made some experiments with it in the dressing of foul ulcers and also in sinuses leading from necrosed bone. When it has been applied to inflamed gums and injected between them and the roots of teeth the redness and soreness has quickly disappeared. It is a stimulant locally when diluted to one in ten or even one in forty. It may be injected, always largely diluted, into and through roots of teeth with fistulous opening. It will cure pain if applied in full strength to an exposed pulp, but by adding an essential oil, such as cloves or gaultheria, it quickly becomes an anodyne and local stimulant and a very feeble coagulator of albumen. As a spray in a two per cent. solution for the nose or throat it is admirable, as well as for irrigating the antrum. *Eulyptol* is composed of *six parts of salicylic acid, two parts crystals carbolic acid,* and *one part eucalyptol.* This makes a consistent paste which will stick to the neck of a tooth or the gum (if previously dried) for a longer time than any other medicament with which I am acquainted. I have used it in treatment of sensitive necks of teeth with success. Its only rival is the oleo-resin of kava-kava. It is a powerful disinfectant but not so potent as aseptol. It has been used experimentally for obtunding dentine, but as yet it does not appear to rank with cocaine, ether or the fluid extract Cannabis indica. It may be smeared into a pulp chamber and covered with cotton soaked in a gutta-percha solution and allowed to remain a few days before using a broach in the canal to remove putrid matter, with success. It is a deodorizer and preservative, and if it has no further good quality than the one of adhering to the neck of a tooth and removing the sensitiveness at that point it is a valuable addition to our armamentarium. *Trichlorphenol* contains three atoms of chlorine in place of hydrogen in carbolic acid. It is not soluble in water but freely so in alcohol, ether, essential oils, glycerine, etc. I prefer solvents in the order named—glycerine, essential oils, alcohol and ether. It is stated to be twenty-five times more powerful than carbolic acid, hence weak solutions are to be prepared. It checks the production of pus, is a stimulant and non-irritant in solutions of less than twenty per cent. and may be used whenever iodoform is indicated as an antiseptic dressing and is a certain disinfectant. Its weak point is non-solubility in water. It forms soluble salts with bases and on this account may prove of value in the treatment of phagedena.

Some one may ask why we should try new and in some cases untried remedies when there are many old and prompt acting agents for use in the treatment of all known diseases. My answer would be, efficiency, potency, non-poisonous properties and palatableness are all sought in the order named, and when a new drug possesses these it is our duty to substitute it for the old, proving our interest in progress, and a determination to base practice on fixed principles of scientific advancement.

In regard to obtundents, a good deal depends upon the operator and his ability to influence the patient. In so many cases of sensitivenes as we have to deal with, we must have some obtundent. Absolute alcohol is good in some places. When the rubber has been adjusted and the cavity dry, pain is more pronounced upon application of any medicine, and especially if it be a cold liquid. It is better to apply the obtundent warm, as there is less pain, and it also increases the local anæsthetic property. Alcohol, or anything that evaporates the water in the tooth, causes pain for a moment, but this soon passes off and we get the desired effect.

In regard to disinfecting; how many know why they use carbolic acid? It would take one hundred and fifty pounds of it to disinfect a room in which there had been scarlet fever, while one cent's worth of bichloride of mercury would do the same thing. It is not enough to destroy the infectious matter, but we must destroy the spores. Every time a probe is used it must be thoroughly disinfected before using on another case. How many have caused swelling, abscess, etc., by pushing such instruments through the apex of the roots? This can be prevented by spraying with some disinfectant before operating. You must disinfect to prevent the entrance of microbes from the air.

◆

AN EXCELLENT OBTUNDENT.

℞—Camphor;
Chloral, āāfʒ;
Cocaine alkaloid, ℥ss;
Sulphuric ether, ʒij.
M.

—[DR. J. S. CASSIDY, in Miss. Val. Dent. Ass.]

REPORTS OF SOCIETIES.

NEW YORK ODONTOLOGICAL SOCIETY.

ABSTRACT OF REPORT OF DISCUSSION ON THE HERBST METHOD.

Dr. Lord: I know but little of the views or experience of my fellow practitioners in regard to this particular method of filling teeth. From what I have seen of it, and from what I know of the principle of manipulating and packing foil, I am not favorably impressed with it. Every dentist has peculiarities in his mode of operating, and it is not safe to condemn any mode of filling which gives satisfactory results. It would seem that the practice of dentistry develops individuality of methods, and as regards instruments used.

Some of the objections and weak points of this method I will enumerate. I regard the matrix and similar auxillaries as a serious objection. The matrix is a useless and a misleading appliance. The preparations for their use consume a great deal of time, and are an annoyance to the patient. The whole operation can be more accurately performed without the matrix. A narrow matrix used at the cervical wall may be occasionally admissible, but a wide matrix obscures the view of the cervical border and interferes with accuracy of manipulation. I regard any plan for filling teeth that requires a general use of the rubber dam and the engine as objectionable. There can be no question as to the feasibility of filling satisfactorily plain, simple cavities, easy of access, by the rotary method, but with hand pressure the same thing can be done more simply and quite as quickly. The rotary method requires too often much sacrifice of sound tooth structure,—a serious objection in my opinion. In filling approximal cavities of the front teeth, part of the labial wall must be sacrificed in order to get the instrument into the cavity, even when such separation as is ordinarily required exists between these teeth. Thus the teeth are defaced and the filling made more conspicuous than would be the case were suitably curved instruments used for packing the gold. I believe it is admitted that the Herbst method is not suited for finishing either the edges or surface of fillings, the finish being made with hand instruments or the mallet. I noticed that Dr. Herbst used hand pressure for a large part of the operation, and my impression was that he was distrustful of his own method. He annealed the gold, which I regard as a great mistake excepting for the final restoration of contours. While I believe every right minded dentist should be ready to hail with delight any improvement from any quarter, over existing methods, I do not think the much talked of Herbst method will ever be so accepted.

Dr. Dwinelle: I have been reported as having endorsed Herbst and his method together. The fact is I have merely said that his system was new and peculiar and that it becomes us not to be too hasty in adopting it as a system; that its value to us was a matter for time and experience to determine. Dr. Herbst certainly is a man of genius and a great acquisition to our profession. I said once we old fogies would not be likely to adopt the system as a whole, though we might make it auxilary or supplementary. Something like the Herbst method has, as most of us know, been for a long time practiced. Planishing gold and working it into cavities by rotating brunishers with the hand, is an old practice. Nevertheless Dr. Herbst is entitled to credit for bringing the matter to its highest expression and organizing it into a method or system. His method in my hands justifies me in predicting that ultimately it will supplant our operations, for I have found it useful not alone for condensing, but for securing *uniform* solidity. Using either Wolrab's gold, or ordinary foil, either soft or cohesive, but especially soft foil in pellet form, gives satisfactory results. I have also made large and perfect fillings by this method, using crystal gold alone. But the Herbst method cannot be made to subserve every purpose without employing in conjunction with it hand instruments to adapt the foil to remote parts of the cavities. Nothing among various ingenious and valuable improvements of Dr. Herbst's stands more prominently before my mind than his method of lining cavities with gold by means of cotton applied against a loose mass of gold in the cavity by means of a rotating brunisher. On removing the cotton the cavity is found beautifully lined with gold. Dr. Herbst uses this method preparatory to using amalgam in front teeth, where economy must be practiced, thus guarding against discoloration.*

---

*NOTE.—Before introducing the amalgam Dr. Herbst varnishes the inside of the gold-lined cavity.—[ED.

Dr. Bonwill is entitled to credit for having brought the malleting system by machinery to its highest perfection. I saw him make fwo fillings at Asbury Park last summer, using his engine mallet, and the work was done with great facility and thoroughness. But both fillings could have been made quite as well by other methods, even by hand pressure. Certain teeth will not bear the first blow of a mallet. We often have to be eclectic in our practice, adopting means to ends and blending various methods. Dr. Bonwill has referred to tests made to demonstrate the solidity of his fillings by passing them through a rolling mill. I do not regard that as a test. An imperfectly impacted filling after being annealed and passed between the rollers of a mill would be so condensed and compacted as to present the same appearance.

Dr. W. H. Atkinson: I have always been an advocate of an open field for the exhibition of any device or invention that tends to the furtherance of our interests. To pronouuce hasty judgments upon them I do not regard as wise, for the reason that each individual's judgment is made up of his separate experience. Principles are not sufficiently understood. There must be an educated hand to obey the intent of the mind in every mechanical operation that we have anything to do with.

I am much in favor of what I regard as the Herbst method, but when I say that, I want to define what I understand the Herbst method to be,—a combination of hand pressure and of rotary motion. So far as Dr. Herbst's genius is concerned, I have conceded that. If you remember his history you will recollect that a great many of these beautiful little movements that seemed to be so easy were accomplishments acquired in another department of mechanics entirely. I admire his honesty in saying that had he known what had been accomplished in America he would never have spent the time and effort that he did to attain the excellence that he has shown. Further than that, he did not consider himself complete, but said he was growing and was to grow. This matter of judging of a man's standing by our interpretation of what he does is a little bit old-fogyish, egotistic and pharisiac. When we are tempted to judge of any man we should remember the old saying: "By what judgment ye judge ye shall be judged, and with what measure ye mete it shall be measured to you again." How many of us understand that so as to interpret it in its legitimate sense?

I think the Herbst method has not been properly appreciated except by a very few. One point that I wish to call your attention to especially is the statement that it is not adapted to finishing the margins of cavities or fillings. If it is useful anywhere, it seems to me that for such purposes it is especially adapted.

I was a great stickler for the mallet. That was because of the processes through which I was led to obtain what ability I have in filling teeth. It came to me by inspiration, just as the plasticity of gold came to me through poverty. At that time I could not afford to lose the gold that was spoiled in filling, so I dried it in a spirit lamp and tried to put it into the central parts of cavities, thinking that by that means I could utilize the gold. It was not that I had such a wonderful erudition about the principles of things, but it was the inspiration of my necessities. I have seen fillings that were made by this Herbst method over two years ago by Dr. Bödecker, on the cutting and approximal surfaces of inferior incisors, and they have stood hard service without showing any evidence of disintegration or leakage. How many of us can say that of fillings made by other methods? That any one method should be transcedentally superior to any other I have not the least idea. As Dr. Dwinelle has said, it is the man behind the instrument, and his perception that makes superior work. We are all the time getting sharper in our criticisms, and sometimes less kindly, forgetting that criticism is not fault-finding but getting at facts.

As to the difference between methods, no man is entitled to pronounce judgment upon them until he has become familar with the different methods that he is comparing. I know I am a little jug handled. I am an advocate of the dead-blow mallet, faced with gold or lead or tin or something that gives a dead blow with no recoil to it. I am against a springing instrument, because I know that the law and nature of impaction requires a dead blow. I think it is too soon for us to prophesy what will become of the Herbst method; but according to the development of our understanding of principles, I think we are entitled to judgment more than those who are not acquainted with the principles we are discussing.—[From report in *Cosmos.*

EDITORIAL.

Frank W. Sage, D. D. S., - - Editor.

CONSERVATISM vs. RADICALISM.

Writers in journals and speakers in conventions frequently furnish amusing illustrations of the power of conservatism over radical impulses. It requires a good deal of moral courage to take a position antagonistic to prevailing opinions, and the man who, like the bell-wether in a flock of sheep, has never leaped over a ditch and then leaped back again, for want of followers, would be hard to find. The "if, but, and provided," which qualify so many expressed opinions, betray the wholesome regard of what may prove to be popular dissent. While it must be admitted that conservatism is the great balance-wheel which keeps the machinery from running away and wearing itself out, no one expects perfect harmony of opinion as to the speed at which the wheel should be required to revolve. Radicalism will occasionally thrust in a hand and jerk at the throttle.

This respect for and fear of the conservative sentiment is all very well so long as it does not unduly restrain individual freedom in expressing honest convictions. Some men apologize in advance, to the body of reading or listening conservatives. Others bethink themselves of this duty later on. Many doubtless remain silent altogether, for fear of disagreeing with the popular majority. It requires the bold, fearless utterances of a pronounced radical, to bring to the front a character who is sometimes present in our conventions. He is not always a man of national or even local reputation. He presents himself as the self-constituted guardian of the sacred precepts of a time-honored school. He chooses a time for confronting his antagonist with admirable regard for dramatic effect, carefully entrenching himself behind the ramparts of ancient dogmas and accepted creeds. With the complaisance of one who feels sure of popular approval, he announces the ground upon which his objections are based, waxing warmer and warmer as he proceeds, and piling up argument upon argument until it appears that somebody must presently be crushed. No one probbly anticipates more quickly than the patient reporters, the character of the forthcoming speech. Behold them laying aside their pencils for a much-needed rest. They know perfectly well that the aforesaid speech may be found in their notes of some previous meeting. To other members of the convention the speaker soon becomes wearisome, because his remarks are in the main superfluous, and needlessly impede profitable discussion. Under the guise of unmasking error the speaker proceeds, often to the complete discomfiture of his less confident opponent, whom all would be glad to hear. These men are not always half as serious as they seem. They very likely win applause from the "gods" in the galleries, but a peculiar savor of sanctimony in their manner offends the taste of sensible men. Any ordinary mortal may mount the pedestal of conservatism and hurl defiance at a Goliath. In the fable, a goat on the roof of a shed reviled a wolf below. No one is deceived by virtuous affectations of concern for established creeds. Everybody wants to hear the earnest man with a new theory or a new appliance. Criticism is supposed to be invited, but it seems hardly necessary, at every appearance of deviation from accepted principles, to call out the reserves in defence of the constitution.

◆

Dr. H. C. Merriam gives his method of filling cavities, difficult of access, as follows: A small piece of gutta-percha is softened by heat and pressed into the cavity after excavation without drying. This gives the impression of the cavity; remove and trim even with the outline of the cavity. This is then dipped in oil of cajeput, heated, the cavity dried, and the gutta-percha carried to place and pressed home. This makes an excellent filling for cavities under the gum where moisture cannot be excluded as the pressing in of the gutta-percha, coated with this soft mass, carries with it the moisture of the cavity and we get adhesion under water.

The Kentucky State Dental Association will hold its seventeenth annual meeting at Louisville, Ky., beginning Tuesday, June 7, 1887, and continuing three days. The meeting will be held at the Louisville College of Dentistry, Chestnut St., between Floyd and Preston; President, J. T. McMillan, D. D. S.; Secretary, Chas. E. Dunn, D. D. S.

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, June, 1887. No. 9.

MEDICAL DEPARTMENT.

TRANSPLANTATION OF LIVING TISSUE.

By C. W. TANGEMAN, M.D.,
Assistant to the Chair of Ophthalmology at the Medical College of Ohio.

In looking over the literature of plastic surgery we find that when we speak of correcting deformities or restoring organs we are by no means dealing with any new feature of the science of surgery. The ancient Egyptian, the Indian, the Roman, during the time of Celsus, speaks of restoring noses and ears by the aid of skin brought from the neighborhood of the organ that was deformed. To trace plastic surgery from that date and eulogize the names of those who became famous for their skill in that connection would lead us far from our subject. Many of the half civilized races punished some of their criminals by cutting off their noses or ears, and since the deformity was so marked and the odium so great, every effort was made to have the organ restored. The surgeon of that day became so adept in the restoration of the cut off organ that justice was to a certain extent cheated, and a positive order was issued that the excutioner burn the organ after it was cut off.

Necessity stimulated the inventive genius of man and he succeeded in manufacturing a respectable looking nose out of tissue taken from the arm, or by flaps of skin from the forehead, etc.

The latter operation was the most successful though it required a good deal of nicety for its proper execution.

For the sake of argument we will be compelled to subdivide the subject of plastic surgery, and will therefore adopt the classication given by Johnson. He divides plastic surgery into five classes:

1st. Where the tissue is brought from a distance but has a distinct pedicle, as in the Taglicothian method of restoring the nose.

2d. Successive migrations, as in the Iridian method.

3d. Sliding of integument from the neighborhood.

4th. Simple approximation of surfaces, as in hare-lip or closure of vesico-vaginal fistula.

5th. The transplantation of totally separated parts, as the transplantation of teeth, bone, and in the transfusion of blood.

It is the fifth and last division which interests us this evening, and it should receive such an impetus that will place it on an equal footing, to say the least, with the foregoing classifications, since there are many cases of deformity that cannot be relieved unless we have recourse to some other means than those usually resorted to. It is not necessary here to note the technical terms that are being used synonymously by various authors to define their meaning of the term transplantation. The word defines itself, viz.: a complete or total separation of an organ or portion of an organ or tissue, with the subsequent transferring and proper placing into position so that it can unite and receive support from its new surroundings. The graft (if you will allow this term to designate the portion to be transferred) need not be taken from the same individual on whom it is to be planted, or from a corresponding member of another person, as Frank Hamilton thought when he suggested that the vagebond father should allow a piece of skin four by seven inches in extent to be removed from his leg in order to close a wound that existed on the son's leg, but it may be taken from an animal or an amputated limb, or even from a dead person where life is extinct but an hour or two. Everybody is familar with the experiments of Abernethy, that can be found in nearly all works on surgery, where he removed a cock's spur and planted it in his comb, and where the tip of a rat's tail was denuded and fastened under the skin of his back, causing it to adhere firmly and maintain its vitality from this source after severing it at the other end. Teeth had been transplanted from one mouth to another, noses were restored after having been cut off completely (as above mentioned), yet this department of plastic surgery benefitted little by these facts. Many and illustrious have been the names of surgeons up to the middle of the 19th century, yet it was reserved for the French surgeon Reverdin to show that skin without a pedicle might be utilized as an agent in the cicatrization of granulating surfaces by transferring it in small bits.

Physiologists know many facts concerning the circulation of blood, but it remained for the studious Hunter to put two and two together to make four. The future will show that the names of Hunter and Reverdin will be placed side by side as great discoverers. The operation was devised for the cure of old chronic ulcers where the reparative process had entirely ceased. A small piece of cuticle placed on the granulating surface causes new activity in the old sore. Not alone does the graft enlarge and reach toward the margins of the ulcer, but the old indolent edges themselves advanced toward the little island of new skin. It was found that any number of grafts could be placed and even extensive surfaces soon healed over. The operation has become general property of the physician and is resorted to as a matter of course for the cure of these cases. It requires no skill to perform the operation, and it is usually attended by the happiest results.

At this point now we want to drop the subject of skin grafting for the cure of ulcers and burns (although nearly all the cases reported on the subject of transplanting refer to the cure of ulcers and burns) and speak of transferring skin and other kinds of tissue in mass without a pedicle.

As the science of surgery advances the profession is called upon to meet the demand that is made. Nature makes an effort to restore diseased or destroyed tissue, but the amount of destruction is often so great that a deformity results unless the surgeon can interfere. The question arises, what kind of tissue can be transplanted, and how large a piece can be transferred? Not every physician can become a good surgeon, if for no other reason than that not every one has the faculty of judging correctly the conditions before him. In many of the plastic operations of to-day the success is entirely due to the surgeon's judgment; if he errs the deformity nearly always becomes greater than it was prior to the operation, because tissue has been destroyed. It is the writer's opinion that the process of transplantation will in the near future take the place of nearly all the various sliding operations, and be resorted to where formerly the case remained without treatment. For the formation of a new eyelid or the correction of a deformity involving the entire eyelid, it is not necessary to disfigure the patient for life by taking a flap of skin from his forehead, cheek, or the side of his nose. It has been demonstrated satisfactorily that a piece of skin taken from the arm will answer equally as well.

Bone can be transplanted, as the following observations will go to prove. A button of bone removed from the skull by the trephine and replaced will in a short time unite with the surrounding tissue by bony adhesions. Small fragments of bone in case of fracture of the shaft of a long bone, will in most cases reunite in the course of time. A fairly well authenticated case was reported not long since where the larger portion of the shaft of the tibia had been removed for disease and the loss of tissue was replaced by a piece of bone taken from an animal, the graft being covered by its own healthy periosteum. The individual made a good recovery with union between the two pieces of bone.

In 1885 Professor Bergman of Berlin is credited with performing rather a unique operation. Two cases presented themselves simultaneously at his surgical clinic, one with disease or necrosis of the upper part of the shaft and head of the humerus, the other a case for amputation of the femur. The excision of the humerus called for an extensive removal of bone, which Bergman supplied with bone taken from the amputated femur. The success of the operation was perfect and gave to the patient a useful arm.

If this theory can be made practicable (and we will look to our surgeons for an answer), gunshot injuries of the extremities, or compound comminuted fractures, where the shaft of the bone is often so much shattered that the fragments must be removed, causing very much shortening or even amputating, may be treated with success by transplantation. The injury to the soft parts in this class of cases would certainly be very much against the success of the undertaking, but by the aid of antiseptics the skillful surgeon of to-day can accomplish what four or five decades ago would have been an impossibility.

If we are told that tendon can be transplanted and unite sufficiently well to give the limb its natural usefulness, then what use is there for so many drooping fingers, and what reason can be given when fingers are amputated simply because a tendon of an extensor or reflex muscle has been severed. Prof. Nicoladoni, Insbrück, reports a case of transplantation of the peroneal tendon to relieve the deformity of clubfoot. Gluck has transplanted tendons, as well as united them after having been severed some time. Oculists do not hesitate to cut one of the tendons of the recto muscles of the eye and give it a new point of adhesion by fastening it with sutures in the position where they want it to adhere.

The transplantation of muscular tissues would seem to be the most difficult to carry out, both so far as the surgeon and the patient are concerned.

Helfrich, of Munich, reported a case to the Congress of Kiel, where he removed a large fibro sarcoma from the biceps muscle of a man, and consequently removed a large part of the muscle; this gap he filled in with the biseps muscle of a large dog, uniting the upper extremity with six catgut sutures and the lower end with thirty sutures. Union took place by first intention, the patient recovering with a useful arm that he could flex and extend at will. Ziemssen examined this case and tested the muscles with electricity, getting a response from the muscular tissue the same as in health, showing that the planted piece of muscle tissue was supplied with nerves.

My friend Dr. Hendley had the kindness to give me the history of the following case that came under his care while resident physician at the Cincinnati Hospital: C. C., æt. 25, 1885, had a portion of his nose torn away in a drunken brawl, while under the influence of liquor. His friends found the piece of the nasal organ and brought it, covered with dirt, wrapped in a piece of paper to the hospital, expecting to find the owner of the nose. He was not there, but after much inquiry at the various station houses and hospitals of the city the man was found and taken to the hospital. The doctor cleansed the piece of tissue with a solution of bichloride of mercury, and by means of thirteen sutures fastened it in its proper position. The result was that union took place with slight notching of the alar, due to a little sloughing of the skin. This piece of tissue, consisting of cartilage and integument, retained its vitality for four hours, even though it had been covered with dirt.

Human tissue will retain its vitality a long time. Small bits of integument used for skin grafting were transplanted successfully 100 hours after their removal. Brown-Sequard has noticed contractility of the iris sixteen days after death; which was possibly due to the action of the alkalinity of the aqueous fluid. Alkaline fluids have the property to lengthen the time of the vitality of tissue. This is of great importance to the surgeon; he can remove such tissues as he may desire, from an amputated limb or from a corpse in the dead house immediately after death, and then prepare his patient for the planting of this tissue. Esmarch has been very successful in making large integumental graftings. The skin in these cases was taken from the arm of the patient. In the first case the operation was for the repair of the nose destroyed by a redolent ulcer of ten years' standing. In another case he removed a large mole from the external angle of the eye, and filled in the space by two flaps of skin, all the wounds healing by first intention: a third case that he especially refers to is one of injury to the chin, necessitating extensive removal of skin area. This space was covered by integument, with the happiest results

It has been my privilege to assist my friend and teacher Dr. Seely, in a number of these grafting operations about the eye. The graft in these cases was cocynuctrial tissue, taken from a rabbit's eye. These operations were made for the relief of lymblipheron or extensive adhesions of the lid to the eyeball. To judge this operation from the results in the above deformity, we would be compelled to give our prognosis very carefully, since a factor that is very essential in this operation cannot be carried out, viz., to keep the graft dry and in close proximity with the denuded surface below. Dr. Aub, of this city, has reported a few cases where he relieved extensive ectropion in children, caused by burn, by means of transplanting integument taken from the arm of the patient. The largest graft used 1 5-6 inches long and 7-8 of an inch wide, and held in position by many fine sutures.

The most interesting case of transplantation comes to our notice through Mr. Chilret, who transplanted the eye of a rabbit to the orbit of a female patient, where he had removed a staphylomatous eye. The result was nearly perfect. The cornea perforated, allowing the escape of the aqueous and lens but not the vitreous; but the nutrition of the organ was complete. H. W. Bradford verifies this procedure by being successful in the same operation. The muscle acted properly and the conformation of the eye was good. The cornea at first became hazy but gradually cleared up. Vision, of course, was not expected, but the patient obtained a very satisfactory artificial eye. I will at this point briefly give the history of one of my own cases.

Harry M., æt. 4, healthy in appearance, sent to me by Dr.

Cassat for the relief of an inability to close his eye-lid. This condition was brought about by caries of the supraorbital ridge. The suppurative process and the subsequent adhering cicatrix caused the lid to be drawn up to such an extent as to give to the child an ugly staring appearance, and at the same time expose the cornea. The first step was to make a subcutaneous operation for the relief of the adherent cicatrix. Little or no reaction followed this operation, but I found that not only was the lid adherent to the bone, but the long continued suppuration had destroyed the structure of the lid to such an extent that there was little space left between the margin of the lid carrying the lashes and the eye brows above. I now made a straight incision across the eye lid from angle to angle, leaving as much tissue as possible on the free margin of the lid. A needle armed with a heavy thread was passed through this part of the lid and then through the tissue just beneath the lower eye lid. By tying the ligature and dissecting up the skin of the eye lid a little the wound made by the horizontal incision became oval in shape, of the following size: 3-5 inch in the vertical end, 5-8 inch in the horizontal diameter. To fill this space a piece of integument was taken from the child's arm about one fourth larger than the wound of the lid. After removing the adipose and subcutaneous tissue it was transplanted to the lid and there held in place by six sutures. A compress bandage made of pledgets of cotton soaked in an atiseptic fluid was placed on and then allowed to remain undisturbed for eighteen hours. The graft looked pretty black at times as though it was going to slough. During the second day the child rubbed his eye and tore out the three upper sutures, making a space of about two lines in width and three lines long that was denuded. This space I covered by a graft taken from my own arm with a scissors, and then put a light dressing on again. From this time on the patient made a rapid recovery. On the fourth day the suture in the cheek was removed. So far as appearance was concerned the graft for some time had a different color, and there remained a cicatrix in the lid. The lid was now long enough to close properly.

I think the above operation open to criticism. The graft seems to do better when not so many sutures are used, and second, not sufficient care was taken to make the proper pressure to insure a continuous and absolute contact of the entire graft to the lid. Dry, cold seems to facilitate the chances of the graft. Moisture and warmth induces decomposition to set in more rapidly. Some surgeons prefer to cover the graft with goldbeaters' skin, so it can be observed without removing the dressing entirely, but use no sutures. Others go to the opposite extreme and put in too many sutures and make no compression. A few sutures to keep the graft in position with a proper compress seems to answer best. The grafts seem to do better when all subcutaneous tissue and fat is first removed, but have also been transplanted without its removal with good results.

If sutures are to be employed great care must be taken that the graft is from one-fourth to one-third larger in size than the wound to be covered. While, when the compress alone is used, this precaution is not so necessary. Nobody doubts the utility of transplanting skin to granulating surfaces, but at the same time experience has shown that no definite rules can be laid down, where this procedure is applicable and exactly how it should be made. Every case is a case unto itself. In gun-shot injuries of the face this operation undoubedly has a great future. Cicatrization causing deformity can be prevented.

The following have been our conclusions after a careful review of the subject:

1. Always observe the most scrupulous cleanliness.
2. Grafting sometimes fails for some incomprehensible reason, even when all requirements are complied with.
3. Accumulation of blood or secretions under the graft may prevent union.
4. Where such a thing is possible the surface that is to receive the graft should be prepared a few days prior to transplantation, thereby stopping all bleeding and oozing.
5. It matters little whether the graft is taken from the same subject, a human being or an animal.
6. A graft or portion of an organ to be transplanted retains its vitality for hours, giving the surgeon ample time to prepare the field for the reception of the graft.

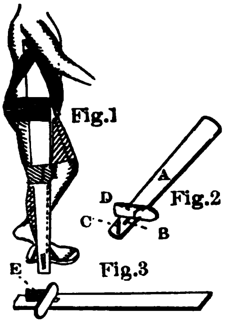
In many cases death of the graft is caused by the large number of sutures employed. The mere contact of the skin is not at all sufficient.

◆

FRACTURES OF THE FEMUR.—THEIR TREATMENT AND RESULTS BY A NEW APPLIANCE.

By J. P. Turney, M.D., Arlington, Oregon.

I desire to call the attention of your readers to a splint which I have devised, and which I have used with excellent results in five cases of fracture of the femur.



The splint, as shown in figure, is simply a piece of wood about three-eighths of an inch thick, and four or five inches wide at the top, tapering to two and one-half or three inches at the bottom, through which there is a groove or mortise about five inches in length by three-fourths of an inch in width, and running parallel with the axis of the splint to about three inches of the end, through which there is a peg about two inches long, and strong enough to resist considerable pressure. There is also a foot-piece, with a tongue which fills the groove in its lateral aspect, and allows motion only in an upward or downward direction. This foot-piece is held firmly to its place by a strap or block screwed on the opposite side as indicated by dotted lines in cut. The splint should be long enough to reach to within three or four inches of the axilla.

Fig. 1 shows splint in situ; fig. 2, A, body of splint; B, groove or mortise in splint; C shows peg; D, loop or staple on bottom of foot-piece; fig. 3, E, shows rubber bandage as applied.

To apply dressing: After padding the splint well, take a piece of adhesive plaster long enough to reach from knee to six or eight inches below the foot, and leaving sufficient width to completely encircle the limb. Cut a slit in the center of the lower end of this, far enough up to allow the passage of the foot; then split each of these halves to above the maleoli on either side; apply as shown in figure, and cover with an ordinary roller. Draw the ends down and fasten to the under surface of the foot-piece. Now take another piece of adhesive plaster wide enough to encircle the opposite thigh and long enough to reach from just above the knee, obliquely around the body to the axilla of the opposite side, and split the upper end down to the greater trochanter and apply as shown in cut, and cover with a roller to prevent the corners from coming loose. Now let an assistant take hold of the lower end of the splint (not the foot-piece) and make firm traction while you fasten the ends of the plaster to the upper portion of the splint; then take another piece of plaster and pass around the gluteal region and fasten to the splint. This prevents the splint working forward and immobilizing the limb. Now pass a roller around the knee and splint, and your work is done with the exception of passing a rubber bandage through the loop in the bottom of the foot-piece and around the peg. You can regulate the extension by simply increasing the number of turns of the bandage, thus keeping up a regular and even pressure all the time.

While I like a plaster bandage in most cases where it can be used, I am satisfied that for a broken femur there is nothing which will give as perfect results and allow as much freedom to the patient as can be had with this appliance, and for compound fracture it is almost indispensible. I append a brief history of two cases treated with the splint. As the fractures were similar, and followed each other so closely that the splint was taken from one limb in the afternoon and applied to another about midnight the same day.

Case 1. –Willie Smith, æt. 15, fell from the loft of a stable and sustained an oblique fracture of the middle third of the right femur.

I was called and, assisted by Dr. C. F. Bacon, applied my splint. The boy slept nicely that night without an opiate, and never complained of pain at any time after the limb was dressed. On the 12th of November, five weeks after the accident, the splint was removed and a plaster bandage applied. The contour of the limb was perfect. By measurement from the greater trochanter to the external condyle of the femur, the broken limb was one-fourth inch longer than its fellow.

Case 2.—November 12th was called twenty miles in country to see Frank Toby, æt. 16 years, whose horse had fallen on him, causing transverse fracture of middle third of femur.

I applied my splint and told his father if any of the bandages loosened to let me know at once. I did not see him again for a little over four weeks, when I removed the splint and applied a plaster bandage. In this case I could detect no difference in length, and the contour was all I could wish.

Summary: The points to which I wish particularly to direct attention are:

1. The principles of extension and counter-extension are utilized to any desired degree, without the use of weights, pulleys, or complicated machinery.
2. The use of a perineal band is rendered unnecessary.
3. By the transverse or gluteal band, the surgeon may secure any desired direction of the foot, a feature of especial importance,
4. The simplicity of the whole appliance.
5. Its effectiveness, as evidenced by clinical results.
6. Its ease of construction, lightness, and portability.

Messrs. M. A. Spencer & Co. are prepared to furnish splints, adhesive plaster and rubber bandages complete.

◆

RETENTION OF URINE.—F. N. Otis, M.D., presents in the N. Y. *Med. Record* a number of cases of retention of urine, from which he draws the following conclusions:

1. The necessity of appreciating the fact that slight urethral contractions, at any point from the meatus to the bulb, are a possible cause of retention of urine, through reflex irritation, and should enter into the consideration of such cases, especially in elderly subjects, whenever such contractions are known to exist.
2. The importance of an early recognition and relief of an acute retention by catheterization.
3. That localized atony at the base of the bladder may be present in sufficient degree to wholly prevent voluntary urination, while the contractile power of the superior portion remains practically undimiminished.
4. The understanding that the failure to relieve, through the removal of sources of reflex irritation which might be considered sufficient to produce and perpetuate the spasm of the muscular urethra, should suggest the possible relief, even in long-standing cases, which may be afforded by an incision of the vesical neck.
5. That any local or general treatment which may be adopted independently of the removal of the cause upon which it depends is of but little avail for permanent cure.
6. That a period of several months of freedom from the cause producing it must not be considered too long to wait for recovery from over-strain or atony of the bladder.

CORRESPONDENCE.

FOREIGN CORRESPONDENCE.

BERLIN, May 4th, 1887.

MR. EDITOR :—Perhaps you have a small space in your valuable journal for a few notes from Germany.

A meeting was held in the Berlin University building recently to honor the memory of Carl Schroder, the deceased gynecologist. The assembly was a large one and had many noted persons from the medical and outside world, also representatives from the government. The meeting was at the call of the Society of Obstetrics and Gynecology of Berlin. The object was, in part, to erect a memorial for the deceased gynecologist. Speeches highly laudatory were made by various persons. Among those present were the widow and nine children. May his tribe never grow less!

Prof. Olshausen, of Halle, has been called to the chair left vacant by Schroder and is lecturing in the summer semester for the first time.

Prof. Kaltenbach, of Giessen, succeeds Prof. Olshausen at Halle in the chair of Obstetrics.

The German Public Health Association will convene in Vienna September 26 to October 2, to meet with the International Hygienic Congress.

Prof. Crede, your correspondent learned at a recent visit to Leipsic, is quite ill from a malady feared to be carcinoma of the bladder.

A visit to my old workshop in the Pathological Laboratory in Leipsic found things quite changed. Not a familiar face was there. Conheim dead, Weigert gone to Frankfort, and Huber was on a trip to Egypt, while six years had changed the faces of the learners without an exception. The dogs, rabbits and pigeons we used to torture were all at rest. Prof. Birch-Hirschfield, Prof. Conheim's successor, seems to have taken up the work just where it was laid down.

The Anatomical Society, newly organized, held its first meeting at Leipsic April 14 and 15. Prof. Koelliker, of Wurtzburg, was elected president. The society has already 190 members, 78 being foreigners.

An article from the pen of Dr. Philip Zenner, of Cincinnati, has just appeared in the Berlin *Klinische Wochenschrift.*

Dr. Nathaniel Lieberkuhn, late of Berlin and the discoverer of Lieberkuhn's glands, died April 17th, at the age of 65 years.

The LX session of the German Association of Naturalists and Physicians will be held September 18 to 24, at Wiesbaden.

The University of Berlin has started out this semester under very favorable circumstances. Dr. Sweninger, however, is still on as Professor.

At the meeting of the Berliner Verein fuer innere Medicine, May 2nd, Dr. Rehmer presented an ingenious instrument by which patients could practice mountain climbing at home and breathe rarefied air also. It was arranged to be used in the Oertel treatment by mountain climbing and exercise to strengthen the heart muscles in heart disease. It can be adjusted so as to make the ascent steep or gradual at will.

The XVI session of the German Congress of Surgeons was held in the Aula of the University at Berlin April 13 to 17. Prof. Volkman, of Halle, was president, and Dr. Gurlt, of Berlin, Secretary. Prof. v Bergmann, of Berlin, was elected president for the ensuing year. The proceedings were of great importance, but of course cannot be reported at any length here.

The VI Congress for International Medicine was held at Wiesbaden, April 13 to 16. The chief points under discussion were pulmonary tuberculosis, its treatment and the question of heredity; pertussis, and the localization of brain diseases. The congress paid very much attention to phthisis, as is its wont. The sense of the discussion was that it was curable in many instances, and fresh air was the treatment par excellence.

This congress was originated in 1882 and was honored with the first promulgation of the tubercular bacillus theory by Koch, whose discovery was made but a few days before the congress met. The meeting here was presided over by Prof. E. Leyden, of Berlin. It took place in what is known as the Kursaal, a beautiful hall. The meeting was held the 13th, 14th, 15th and 16th. A reception to make the members acquainted was held on the evening of the 12th. The attendance was large from the first. The number of members at the meeting previous to this one was 209, since which time seven have died, leaving 202 at the beginning of this congress. Twenty-two new members were added, making in all 224, or 15 more than last year. The number in attendance this year was 249, last year 234. The secretary of the congress is Dr. Emil Pfeiffer, of Wiesbaden. The congress in session presented a fine looking body of men. They seemed to all be middle-aged. Those not included between the ages of 35 and 50 years would not have numbered a dozen. There were more Professors than I ever saw in my life. Every man seemed to be a Professor, or if not that a private Docent waiting for some Professor to die. The general practitioner seemed to stay at home. The plan of the congress was to meet at 9 a.m. and hear two lengthy papers on a subject announced the year before by two gentlemen, of note, appointed to read at the former session. These papers were read from a high pulpit-like arrangement and were anywhere from a half hour to an hour and a quarter in length. After both papers were read the subject was opened for discussion, which was generally taken part in by gentlemen called on by the presiding officer. The discussions were brief and to the point, an average of three taking part on each subject. The afternoon session convened at 3 o'clock, after an intermission of two or three hours. Here a number of papers were read by gentlemen on the program on various subjects; also some demonstrations made and patients shown. The discussions were carried on as in the forenoon. Adjournment was made usually at 5 p.m. No evening sessions were held with the exception of one session each of the executive and committee on admissions. The attention paid was usually quite good and the close of the paper was always greeted with applause (whether for the quality or the quitting I am not able, in every instance, to say). Candidates were nominated by a member, in writing, and voted for by ballot after passing the committee on admission. Each candidate must receive two-thirds majority, the voting being done by mail about New Year's. Members must pay 15 marks ($4.75) yearly. There are also what are called Theilnemers (part takers), which any physician can become for one year on the payment of 15 marks. The latter cannot vote, but take part otherwise. A sumptuous banquet was spread on the evening of the second day. A number of toasts were made and responded to by men prominent in the congress. The congress attended very closely to business and did not waste its time in beer halls, as has been claimed. Wiesbaden was chosen as the place of meeting next year.

If the editor remembers, it is just six years since he and I received our doctor diplomas. Since then mine has been called for on but three occasions. Once, on desiring to become a member of the Cincinnati Academy of Medicine, I received a card from the chairman of the committee on admissions—everybody knows him—to present my diploma and myself at his office between the hours of 1 and 3 p.m. The day was hot and my courage weak, but I went. He wisely scanned the Latin, endeavored in vain to decipher the signatures, and I was passed. Once was at Leipsic. The police demanded a pass. I had no pass. They blustered a little when I produced my diploma. They went through the same scene described above, allowed me to stay in the town, but kept my diploma while I staid as security for my good behavior. I passed on to Berlin. Here I was taken for a social democrat and a pass demanded. I, of course, had none. Things took on a serious aspect. I produced my parchment. The police captain was honest. He said he could not read it. Things began to look like I would have to seek a more congenial clime. I applied to the U. S. consul. He referred me to the U. S. minister. On his verification the policeman scowled, had me translate the date and name of the institution, and passed me. Conclusion: A diploma is a good thing to have. Every honest doctor should have one. If you have any doctors (?) in the medical societies in Cincinnati who have no diplomas, "put the rascals out." E. S. McK.

◆

MEDICAL PRACTITIONERS AND DENTISTS.—A question is raised by a correspondent of the *Journal of the British Dental Assocation* as to the propriety or taste of medical practioners charging full fees where they are asked to attend dentists. Our opinion is strong that medical men who owe so much to dentists will find it highly agreeable to to be of any service in return. Who that has had a tooth saved, or even a tooth skilfully extracted, and who knows the extent to which dentists are consulted by medical men and their families, and the unfailing kindness which is experienced in this way at their hands, will have a doubt that in treating dentists as we should treat medical men we are acting on the best instincts of human nature, as well as on the best traditions of the profession? We have, however, always maintained that dentists should hold a surgical as well as a dental qualification, in which case the question need not have been raised.—*The Lancet.*

EDITORIAL.

A. B. THRASHER, A.M., M.D., Editor.

THE BERGEON TREATMENT OF PHTHISIS.

The treatment of phthisis by means of gaseous rectal injections is now the fashion. The public by means of the lay press are informed that a cure for consumption has been at length found, and patients insist that the treatment be fairly tried.

From all this clamor some harm and some good may result. Harm, by the spread of the idea that, heretofore, cases of consumption have not been cured by other means; good, by the discovery of an adjuvant in the treatment of an obstinate disease.

Perhaps the majority of cases of incipient phthisis recover, with or without treatment. Then it is said that the patient suffered only from a cold. When, however, the case has progressed until every one recognizes the presence of the dread disease, then do we usually find our efforts to check its course futile.

If the new method of treatment should prove of benefit in any or all cases then we can congratulate ourselves on the addition to our armamentarium. The treatment is now having a thorough trial in France and America, and even the sober English physicians are at length giving it some attention.

There are many theories as to the method of action. The germ theorists believe that the gas is absorbed by the blood and exercises a germicidal effect on the tubercle bacillus. Others claim that there is an increased nutritive power imparted to the tissues, thus giving increased ability to resist the attack of the germ, or rendering the soil unsuitable for active germ development. There is still another view in which the beneficial effect is limited to an increased activity of the alimentary canal, by which more food is assimilated and the reparative processes exceed the waste, and by this means the good is accomplished.

But the *rationale* of the treatment is a secondary consideration; whether it is of advantage at all is yet under trial.

◆◆◆

MISCELLANY.

WILL THE KNEE JERK DIVIDE TYPHOID FEVER FROM MENINGITIS?

By ANGEL MONEY, M.D., M.R.C.P.,
Assistant Physician to the Hospital for Sick Children, and to the Victoria Park Chest Hospital.

Dr. Hughlings Jackson asserted a month ago, at the Medical Society of London, that loss of the knee jerk might prove of service in the diagnosis of meningitis from typhoid fever, for he had never known the knee jerk to be absent in typhoid fever, while he had found it to be wanting in cases which the necropsy ultimately proved to be meningitis. Our "friend in need," the knee-jerk, indeed, appears to be, considering its apparent triviality, of as much, if not more, value than almost any other clinical phenomenon.

At the same meeting of the Medical Society at which Dr. Jackson's announcement was made, Sir Dyce Duckworth seemed to put a damper on the President's suggestion by asserting that the knee jerk might be absent in undoubted typhoid fever. Two years ago I recorded in *The Lancet* my experience of the reflex actions and other nervous phenomena of typhoid fever, phthisis, and other continued fevers (pp. 843 and 1069, vol. vii, 1885), and I can only add that my further experience does but confirm what I then stated to be the condition of the reflexes and muscles in these various diseases. The suggestion forces itself upon us that prolonged pyrexia, with all that it involves, whether in the way of direct deterioration of protoplasm by the fever heat, or of indirect deterioration of the same by collateral consequences of the pyrexia, is the cause of the very general exaggeration of the deep reflexes and muscular irritability to be found in the diseases mentioned. I have not seen a case of typhoid fever in which the knee jerk was lost, though the jerk may have been absent on the day or so preceding death in fatal cases, which are rare at the age at which tubercular meningitis is common. On the other hand tubercular meningitis does not always cause the disappearance of the knee jerk. Sometimes the knee jerk is increased in cases of undoubted tubercular meningitis, but only, I believe, when the child is unconscious or nearly so. I have also observed, in company with Dr. Gee, that tapping of the patella tendon on one side caused powerful contraction not only of the quadriceps extensor of the same side, but also of the adductors of the thigh of the opposite side, in a case of tubercular meningitis. Such phenomena will not be found to be very uncommon if they be diligently searched for. I have myself seen them in diphtheritic paralysis, as well as in tubercular meningitis and phthisis.

In order to answer, so far as is possible the question which forms the title of this brief communication, I shall formulate the following propositions: Given a case of fever with morbid mental phenomena, without a typical rash, optic neuritis or choroidal tubercle, or any sign of cranial nerve paralysis or irritation, if the knee jerk is lost on both sides during the illness, and the wasting of muscle is unattended with loss of response to the faradic current, the diagnosis should be meningitis rather than typhoid fever. If the knee jerk be exaggerated and if there be ankle clonus, no certain conclusion can be drawn, for these conditions occur both in typhoid fever and in meningitis (and other conditions). But I am inclined to assert—though on this point I desire further observation and investigation—that increase of the jerks, with or without ankle clonus, accompanied by lively spontaneous flickerings (fibrillar contractions) of the muscles, is much more likely to be due to prolonged pyrexia than to direct disturbance of the nervous functions from meningitis or other nervous irritation. If typhoid fever be complicated with myelitis or meningitis—complications of rare occurrence—then the jerk may be lost, but with a fairly large experience (I have carefully tested the point in twenty-five cases) I have never known it to be absent; while in tubercular meningitis its disappearance for a few hours or a day or a few days, is by no means rare. A variable state of the knee jerk, e.g., one day present, next day absent, and a third increased, points to meningitis and not fever.

To make what may be considered a curious comparison, I should think that the differential diagnosis of meningitis from mere fevers might be assisted far more by the state of the knee jerk than by the swelling of the spleen; for unless the splenic enlargement be enormous, tubercle as well as typhoid fever and other diseases, e. g., pyæmia, will account for the splenic swelling, whereas absence of the knee jerk, or rather ascertained disappearance of the same, is practically never met with as the simple outcome of prolonged pyrexia.—*Lancet.*

Harley-street, W.

THE CLIMATE OF COLORADO.—The following from the London *Lancet* furnishes excellent foreign testimony as to the value of the climate of Colorado in phthisis:

In reference to an inquiry recently inserted in our columns, Mr. T. Laffan, of Cashel, sends us a letter, from which we make the following extract:—"I must say, from experience and a long residence in Colorado and the adjoining territories, that the climate is unsurpassed. To those suffering from incipient consumption, by proper attention to exercise, such as hunting, fishing, etc., there is no question but in a short time all traces of the disease will disappear. I have known young men who went there eight or nine years ago as hopeless invalids, and after a few months' sojourn returned to their eastern homes rugged and robust men. Those far advanced in consumption will have a hard time of it as regards breathing, owing to the extreme lightness of the atmosphere. For such the equable temperature of New Mexico is more suitable. As a resort I would recommend the San Louis Park; it is a beautiful valley, extending several hundred miles, running north and south from Del Norte, Colorado, to Santa Fé, New Mexico, and over twenty miles wide, between the Sangré De Christo and Conejos range of the Rockies, with an average of about 4,000 ft. elevation by sea-level. Game abounds, and fishing in the Rio Grande river, which runs through the valley, is excellent. The winters are not quite so rigorous as in the mountains. I have seen men in that country who were so emaciated physically that their life was not worth a cent. Profuse expectoration appeared to trouble them most. In a short time they became hale and hearty. Persons in an advanced state or period of the disease suffer much; they even bleed from the nose and mouth on the least exertion. This is owing to the high altitude and light air. But the Mexican people say that by drinking tea made from the mild mountain sage all traces of the disease are eradicated; and no Mexican is troubled with consumption that is to be attributed to climatic influences."

BOOK REVIEWS.

EVACUANT MEDICATION.

By Henry M. Field, M.D., Professor of Therapeutics, Dartmouth Medical College; etc., etc. Philadelphia: P. Blakiston, Son & Co. Cincinnati: Robert Clarke & Co. Price $1.75.

This little volume of 288 pages gives, concisely and clearly, the derivation, history, pharmacy, practical applications and contra-indications of the more eligible cathartics and emetics.

A section on "Differential Therapeusis" gives, in condensed form the preferences and contra-indications in the selection of a cathartic to meet certain conditions.

The theory, mechanism, form and time of administration of this class of remedies also receive appropriate attention; and a few pages are devoted to a useful consideration of the *arrest* of vomiting.

The work is eminently practical in scope and design, and the immense mass of literature on the subject has been apparently well sifted in its preparation.

Most writers in *materia medica* would do well to imitate its style in brevity and diction, while there are few physicians whose perusal of the volume would not be followed by benefit to their patients.

WYTHE'S POCKET DOSE DOOK. Containing the doses and uses of all the principal articles of the Materia Medica and Officinal Preparations, arranged in alphabetical order, etc. By Joseph H. Wythe, M.D., Professor of Histology and Microscopy, Cooper Medical College, San Francisco. Seventeenth Edition. Completely rewritten and enlarged. Philadelphia: P. Blakiston, Son & Co. Cincinnati: Robert Clarke & Co. Price 75 cents.

This is *the* pocket dose book, and this edition brings it down to the very latest in everything. Every practicing physician should have a copy and use it.

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, June, 1887. No. 9.

DENTAL DEPARTMENT.

HERBST ROTATION METHOD vs. THE AMERICAN SYSTEMS OF FILLING TEETH WITH GOLD.(1)

By DR. W. G. A. BONWILL.

You wish to know what I think of Herbst's rotation method; have you seen him operate? have you practiced it in or out of the mouth? If any one went oftener to his clinics, gave him closer attention, and was more regardful of the delicate position he held while there, I would like to see him. No one could have had more interest as to the results, for no other system seemed so counter to my own. If rotation was as applicable as its advocates claimed, my experiments and life work must go down in the general wreck. From the first I never doubted that gold was capable of being packed solidly by such a motion, and afterwards rolled into plate. Those of us who have gone through every phase of filling, with hard and soft foils, from hand-pressure to the mallet, can see both the success and the failure, whether it was to the material used, the force, the character of the tooth-substance, or the relations existing throughout. Have all our efforts been in vain, and are we to fly at this juncture to other methods we know

---

1. Dr. W. A. G. Bonwill, of Philadelphia, has written the editor requesting a republication in this journal of his paper read before the N. Y. Odontological Society. We regret that our space is too limited for its reproduction in full; we therefore present a synopsis which we believe embodies all his important ideas.—ED.

not of, and indorse the last departure without qualification, as some have so vociferously done? How many can say we have exhausted the forces once used; that we need a new force, or another mode of application?

Before I pass to the merits of this issue let me say that while upholding my own country and its system, I shall endeavor to treat our departed brother with all fairness and respect. He was fair enough to say to us that could he have seen such operations and instruments before he commenced his rotation method, he would not have come here to exhibit his life's efforts.

What is claimed for this new application of force? Perfect adaptation to the walls of frail cavities; greater speed and less labor to the operator; that it is more comprehensible and easier of adaptation under all the varying circumstances that confront the modern dentist; that it offers a greater reward to otherwise poor operators under other systems, insures to the patient better results, compels the use of pure gold; that it is the only method by which soft foil can be packed and made adhesive. We follow Dr. Herbst from the start. Has he prepared his cavities to avert the subsequent action of the first cause of caries? Has he not shaped them to allow of the use of his matrix, without which he could not operate successfully? Must they not be shaped so that the rotator can reach all points? Has he performed one operation solely by rotation? Does he not, after using the rotators, test every part of the gold surface with a sharp-pointed instrument? Does he not first attach each piece of gold by hand-pressure? Knowing what we do of the subsequent causes of failure, would we shape our cavities as he did, leaving large portions of tooth structure to come in contact afterward? Would we sacrifice so much tooth-structure on labial and buccal walls of incisors in order to reach the cavities with the instruments he uses? We who have been accustomed to so much space would not feel like shutting out light and sight by using a matrix. Would we feel safe in allowing the burnisher to come directly in contact with frail edges of enamel, as he unavoidably does? Who would not rather have a surplus edging of gold at the margins, than merely enough to make a flat, square joint with enamel? Frequently he uses large securing pins. How much room remains for rotation? Then we need the tests of trial and time to confirm his claims. With hard foil no operator who can use the mallet needs a matrix once in a hundred times.

Dr. Bonwill, at this stage, dwelt on the superior merit of the electric and mechanical mallet as a means of spreading gold towards the edges of cavities, at the same time condensing it. He stated that the face of the plugger should be slightly convex, like the hammer used by gold-beaters, so as not to cut the foil against the edge of enamel. The claim made that the Herbst method cannot be employed excepting with the purest gold is not sustained, by the fact that Dr. Herbst himself supplied a lack of Wolrab's gold with Abbey's foil, using it with the same apparent ease and effectiveness. The Herbst method may be easier for the patient, but he would not like to grant that, in advance. While the freedom from concussion may be less irritating to the nerves, rotation makes a constant sound that must tend to annoy. Hand-pressure, incident to the method, is fully as objectionable as the mallet, since it consumes time and tends to move the head out of position. There is, withal, an element of uncertainty in the fact that the gold may not adhere if the burnisher becomes too smooth. I must then reject the method, in toto, since I can see in it no advance or possibility of my doing any better than I am doing, except as practice tends to perfection when kept in one line. And as it takes quite a life-time to learn to do well it would be rather hazardous for me to change my methods. Too much stress is laid upon the *packing* of gold by the Herbst method. It is not all of saving a tooth, to fill it. If anything is of more value than another, it is the shaping and smoothing of the walls of the cavity. Before condemning the oldest and latest American methods, let them be tried without prejudice. We have so many in our ranks who are not of the stuff to make fine operators, and who are ever upon the wing to be helped, that they cannot and will not rely upon any method, be it ever so successful.

Dr. Bonwill rejects the assumption that Wolrab's gold is in any respect better than any American gold-beaters have produced. Abbey's foil (which is not alloyed, as some have supposed) is as pure as Wolrab's, and if annealed by placing on a platinum sheet or plate instead of exposing it directly to the flame, it has no superior. For his own uses he finds nothing better. * * * *

In the discussion which followed the reading of the paper, Dr. C. F. W. Bödecker stated his opinion that the Herbst method is not antagonistic to hand-pressure, the mallet, or methods that have long been in use. The method may be advantageously employed by the novice to pack gold against the walls and margins, finishing the operation in the accustomed way. He thinks there is something in the Herbst method worth adopting. Has for three years employed this method in commencing fillings at least, completing the operation with the mechanical, electric, or hand-mallet. Patients invariably express their preference for the new method. To-day he completes the operation from beginning to end with the Herbst method, and feels assured of their standing as well as if completed with the mallet. Thinks many cavities can be better filled by hand-pressure than by the mallet. Would often use hand-pressure in combination with the mallet, just as he uses it with the Herbst method, because of inaccessibility oftentimes, in either case. As to the preparation of cavities for the Herbst method, it does not at all differ from the manner of preparation for filling by other methods. Dr. Herbst's matrix is prepared in a minute or two. By its use the patient is saved pain and annoyance of finishing, especially in cavities near to or under the gum. Is sincere in the statement that every filling inserted by himself according to this method, has stood every test. Thinks there can be no doubt of the impossibility of securing as perfect adaptation by the use of any mallet, as by rotation. Tests made by filling glass tubes confirm this opinion. Thinks there is no absolute necessity for using German gold; more care, however, is required in using other kinds. Prefers American gold for the centre and grinding surface of fillings. For four months has not used the mallet at all, because he finds the garnet burnisher will condense the surface a little better than the mallet will. Does not claim that the manipulation is easily acquired. After three years' practice he acquired sufficient skill to feel confident that he could pack gold as well with the burnisher as with the mallet. Any one who has packed gold by the rotary method, using an agate or a garnet stone, will have noticed that the surface of the gold is very much harder than it can possibly be made with the mallet.

Dr. N. W. Kingsley * * * * * The Herbst method seems, after all, to be only another way of doing what we have been doing all along, and in the opinion of many we have been doing it a great deal better.

At the conclusion of Dr. Kingsley's remarks, of which the merest outline is here given, several members added a few words. A resolution to the effect that the Herbst Method be made the subject for discussion at the next meeting was offered. Adjourned.

CROWN AND BRIDGE WORK AND CONSERVATIVE DENTISTRY.

At the January meeting of the Pennsylvania Odontological Society, held in Philadelphia, Dr. Chas T. Essig, M.D., D.D.S., read a paper, part of which we present.

* * * In the present status of bridge-work there seems to be a greater desire to originate than to conserve, and some of the methods described in the journals are not only impracticable, but quite ruinous to the sound, natural teeth to which the fixtures are often attached. Take, for example, the method, "Pin and Plate Bridge," described in the *Dental Cosmos* for March, 1886, wherein the writer describes "a typical case," in which a lateral incisor (crown and root) has been lost, the cuspid and front incisor, fully vitalized, and without approximal carious cavities, remaining in position. To meet this loss he prepares a porcelain lateral tooth, to the backings of which are two pure gold wings, swaged to fit the palato-approximal surfaces of the cuspid and incisor, and attaches this appliance to the cuspid and central incisor by platinum rivets, attached to the wings or palato-approximal base plates, and fitted into small cylindrical openings drilled into these previously sound teeth, and fastened there by means of oxyphosphate of zinc.

Strength and impermeability are indispensable requirements in any method. Whether pure gold plate of No. 26 and oxyphosphate cement fastenings offer a reasonable promise of withstanding the great and constant force exerted upon such a fixture, may, I think, easily be determined without a trial. Upon the strength of the fixture depends its immobility and consequently its permanence. If the bridge is not absolutely immovable, it will not be impermeable, and in the absence of that characteristic destruction of the teeth to which the pins are fastened must soon follow. Such examples of so-called bridge-work look well on paper, but let us make a careful comparison of the "typical case" above mentioned and the ordinary method of replacing the lost tooth by the removable partial gold plate, which it is intended to supersede.

What are the great objections to the usual form of artificial dentures? They are three in number:

1. The presence of a plate covering the roof of the mouth.

2. A certain amount of instability, which depends, however, upon the skill displayed in the construction of the fixture.

3. The necessity which often arises of attaching the partial denture to the natural organs.

Let us admit at once that clasps are more or less injurious to the natural teeth; but is the kind of bridge-work described in the above number of the *Dental Cosmos* less so? Is it not reasonable to assume that the friction due to the slight motion of the removable plate, together with the facility with which it can be removed and thoroughly cleaned, will, in a measure, protect the natural teeth to a greater extent than where the clasp or fastening is not removable, but just as permeable? Of course the answer to this question must depend upon the stability of the bridge, but we have no right to experiment upon the natural organs of our patients when such experiments may involve their loss; nor do I deem such uncertain work necessary in the hands of experienced dentists. Such members of the profession will look the question squarely in the face, and recognize at once that. all attempts to anchor bridge-work to vital teeth are objectionable, and not usually attended with good results.

In the article to which I have alluded is also described a case of bridge-work for the replacement of two molars and one bicuspid, by fastening to the first bicuspid and the third molar, by means of crown plates or caps swaged of gold. It will be noticed particularly in the case of the first bicuspid, that "the crown plate" or partial cap is so constructed that every part of the tooth is covered except its buccal surface, thus offering an extensive margin for the ingress of fluids. That such a fixture, depending upon the very superficial anchorage afforded by openings made in vital teeth, can be exposed to the tremendous force exerted in masticating without loosening and displacement, seems hardly possible, and that the partial cap described there as a means of embracing the first bicuspid will remain close enough to exclude moisture I do not for a moment believe.

The employment of such means of attachment to vital teeth I deem most censurable. I do not wish to be understood as expressing disapprobation of all kinds of bridge-work, but I do condemn all procedures of the kind where the operator drills into or mutilates vital teeth for the purpose of forming anchorages, because that is not conservative dentistry.

The application of bridge-work to pulpless teeth certainly offers more encouraging prospects of permanence, and is in every way less objectionable.

The abuse of this method, when fastening to devitalized teeth, will be likely to consist in the hopeless attempt to make three or four roots sustain the masticating force of an entire upper or lower denture of fourteen teeth; but even in such badly directed application of the bridge method the harm will be most likely to fall upon the patient's purse, and may not inflict irreparable injury to valuable teeth. Still, there are many instances in which the immobile fixture will be found to be in every respect superior to the removable plate; but the prospective permanence of the fixture is the feature which should decide the question. * * *

A writer from whom I have quoted makes the statement that "experience has fully demonstrated that a slight mutilation of a vital tooth is far less destructive in its ultimate results than is the wearing of partial plates."

I have met with no such conclusive evidence in favor of mutilation, nor do I believe that the method has been sufficiently tested by time and the forces to which its function must subject it to warrant the belief that it should supersede in all cases the removable artificial denture. * * *

I have noticed that the apprehension of the idea of permanence in connection with this subject differs widely in different minds; but it is not unreasonable to expect the durability of bridge-work to be at least equal, if not superior, to the old and tried method which it is designed to supersede. I have seen many partial dentures which had been worn with comfort and safety to the remaining vital teeth for periods varying from fifteen to thirty years. How many examples of such bridge-work in connection with mutilated vital teeth will last that long?

In the description of "The Pin and Plate Bridge" from which I have quoted it is admitted, even this early in the history of the method, that a very few cases have become loosened, the bridge being for some weeks still worn in the loosened condition, and that under such circumstances the cement will, of course, become detached and wash out, admitting food and secretions.

It is hard to conceive of a worse result, and in the majority of such cases rapid decalcification of the enamel under the loosened plate would be sure to follow.

Placing systematically the different methods of attaching bridge-work to the natural organs with reference to their probrble permanence and capacity for usefulness, that plan in which the anchorage consists exclusively in the cap or ferrule, in connection with the pin or dowel, adjusted to devitalized roots, will be regarded as ranking highest in all the qualities which care and judgment should demand for such a fixture.

It is the so-called Richmond crown, either singly or in numbers united so as to constitute a bridge, and where each tooth is fastened to a sound root. The superiority of this method over all others does not alone consist in the impermeability which is afforded by the cap or ferrules, but in the fact that it also removes strain from the long axis of the tooth to the alveolar socket, where it properly belongs; and this prevents the very common occurrence of fracture of the roots. * * *

An attempt to utilize the screw and nut in bridge-work cannot fail to be regarded as retrogressive.

To meet this objection movable fixtures have been recommended. One of these is described in the "Hints and Queries" of the *Dental Cosmos* for September, 1886; but as the security of the fixture depends upon attachments to the natural teeth by means of several gold screws, it is in no respect an improvement over the ordinary artificial denture, and its employment would be much more destructive to the vital organs to which it is proposed to attach it.

The abuse of the immobile fixture already alluded to, wherein two roots are frequently made to sustain the masticating force of six or more teeth, has done much towards bringing bridge-work into disrepute. That such unequal distribution of force can afford a reasonable promise of permanence is not probable, unless the wearer of the fixture is fully informed of its deficiency and exercises unremitting care; but under those conditions it could not be claimed that such a specimen of bridge-work was fully useful. * * * —*Cosmos.*

Partial impressions should be well flooded with water just before the plaster is poured. The plaster should be mixed considerably thicker than usual, as the water left in the impression will mix with it and render it thinner. After the impressions of the teeth are filled, pieces of wire may be dropped into them to strengthen them. A cast from a well-drenched impression will show but few; if any, air bubbles, as the water leads the plaster over the surfaces and into the depressions.—*Dental Advertiser.*

EDITORIAL.

FRANK W. SAGE, D. D. S., - - Editor.

The approaching meeting of the International Medical Congress, which includes a Section on Dentistry, has awakened among dentists renewed interest in the various mooted questions concerning the relation of dentistry to medicine.

At the March meeting of the Central Dental Association of Northern New Jersey Dr. Norman W. Kingsley read a most interesting and able paper on "The Present Relation of Dentistry to Medicine." Dr. J. Foster Flagg also read a paper, entitled "Dentistry more than a Specialty of Medicine." We regret that space will not admit of a republication in these pages of these two masterpieces. No mere synopsis could do justice to them. Both gentlemen assumed that the nature of dental science and practice is such as to entitle it to consideration as an independent profession.

To attempt even an enumeration of the numerous arguments *pro* and *con*, relating to this question, would occupy too much space. *Cui bono?* A single extract from Dr. Kingsley's paper shows the animus of what followed: "In the discussion which has been called out in dental societies and dental journals I see the facts of history and the inevitable tendency of the times completely ignored, a weak and silly craving to be something we are not, taking the place of honest self-respect, and a sickly sentimentalism about a parentage which never existed, substituted for argument."

Years ago we listened, on various occasions, to discussions bearing on the question, Is dentistry a specialty of medicine? Then, as now, we regarded the propounding of this query as vain and unprofitable. We never believed dentistry to be a specialty of medicine. Supposing it should be clearly demonstrated that it *is* a specialty of medicine, would not the conclusion involve as an inevitable sequence the further conclusion that ninety-five per cent. of the dentists, in America at least, are pretenders? Dentistry has become sufficiently established as a science to justly claim distinction as an independent profession. No one denies that it is often an advantage to a dentist to have familiarized himself with the entire field of medical science. At the same time the science of dentistry as taught in our schools to-day includes enough of medical science to enable the practising dentist to recognize conditions requiring the assistance and coöperation of the physician. It is not an extravagant statement, but a simple and plainly demonstrable fact, that the graduates of our best dental colleges are qualified to pass the same examinations with medical students, in anatomy, physiology, chemistry, histology, and to a limited extent in materia medica, pathology, and therapeutics. Why should the dentist then regard it to his own discredit that he is not competent to step out of his path and administer to disorders which do not properly come within the scope of his profession? In criminal cases the lawyer freqently calls in medical experts to supplement his own crude, imperfect knowledge of medical science. He has oftentimes not even the slight advantage of knowing wherein his ignorance consists. And yet it in nowise reflects upon his claims as a gentleman of intelligence, that he knows little about medicine. Is not that exactly the position in which we, as self-respecting dentists, may hold ourselves towards the medical profession? Look at the impetus which has been given to dental literature within the last decade. Who will venture to say that there is not enough that is new, useful, even indispensable, to occupy the leisure of every progressive dentist for years to come? We have already reached a period that just reason for suspicion arises when any one complains that his ambition is not satisfied by what it feeds upon in the limited field of dental science. We mean no aspersions upon any man. But he who is at heart interested in dentistry, *per se*, will find his attention fully occupied in mastering all that is to be learned in this field.

There has been a deal of senseless vaporing about charlatanry in dental practice. Some would even put an injunction upon the dentist's using medicaments who is not familiar with all the resources of materia medica, and who is not able to write a prescription according to standard formulas. This is plainly begging the question, for it assumes that the dentist should be a physician. If it is too much to assume that the dentist who uses remedies intelligently,—with correct understanding of their nature and operation, —can, without danger to his patients effect the end he seeks, we are willing to be corrected. The dentist who uses remedies intelligently is not a charlatan. He may fail, at times. But does the physician never fail?

Dentists are not the only ones who aspire to the medical degree. You may find merchants who have responded to the promptings of ambition and acquired degrees which were useful only as a means of gratifying personal pride. The doors of the medical schools are open to all who are worthy to enter. But it seems to be no longer a question that the man who expects to be absorbed in the interests of dental science has no special place among physicians.

TO BE BORNE IN MIND.

Since the introduction of the various felt foils, or gold and tin foils combined, for the foundations of fillings, a new and peculiar danger threatens every operator's work, viz., the danger of having remote borders of fillings tested for decay with instruments which may mar a filling in reality perfect, but which through discoloration of the tin presents the appearance of failure. It is well to instruct the patient to forewarn another dentist who at a future time may make examination of the character of the fillings. It is not always an easy matter, even for a dentist who is definitely informed, to determine the true character of the dark line at the cervical margins of such fillings in molars and bicuspids.—[ED.]

After having filled approximal cavities between molars and bicuspids, patients frequently complain of soreness aggravated by food crowding into the space, especially where the gum has been injured by wedging or by the finishing tape. The dentist is often perplexed by this condition of affairs, even where a full contour has been faithfully restored. A reliable remedy is to place between such teeth a thin slip of tape or a roll of cotton saturated with tannin and glycerine, so adapted as not to press unduly upon the gum. This may be left a day or two.—[ED.]

In mixing plaster of paris, if as much sugar as will lay on a silver five-cent piece is added to the water used, the cast will be found to be surprisingly hard, even if the plaster should be poor. For quick setting, both sugar and salt may be added. The addition of alum or cream of tartar will retard its setting.—*Dental Advertiser.*

BIBLIOGRAPHY.

A SYSTEM OF DENTAL SURGERY, by Sir John Tomes, F.R.S. Third edition, revised and enlarged by Charles S. Tomes, M.A., F.R.S., with 292 illustrations. Philadelphia, P. Blakiston, Son & Co., 1887. Cincinnati, Robert Clarke & Co.

In this, the third edition of Dr. Tomes' standard work, the touch of the reviser's finger would be apparent even to one unfamiliar with preceding editions. While the work is comprehensive, much is omitted which in the latest American dental literature finds a place. The statement is not made as a criticism, however. So much has been written that bears collaterally on the subject of dental surgery, that probably no two authors would agree as to what is most worthy of preservation in the pages of a work designed to be standard. The reviser in various portions of the work reviews the theories and opinions of various scientists and frankly appends to them his own views, whether opposed to or in harmony with them. The latest authoritative conclusions of histological research seem to have been overlooked. Under the head of materials for filling teeth eclectic treatment is evidently recommended, in which respect the author is in harmony with a growing sentiment among American operators. In view of so much that is excellent and incontrovertible in the teachings of this work, it would seem almost finical to point out the few minor defects which appear in its pages; especially so in view of the fact that any one at all familiar with current dental literature will know where modification is required. No one will be likely to complain that the work contains chapters on subjects which are extraneous to the subject of dental surgery. As a practical hand-book its excellence will be readily recognized.

◆

If a coil of sheet zinc is put into the water in a vulcanizer, it will prevent the formation of much of the black oxide which is found on iron flasks and clamps. After the zinc has been used three or four times the flasks will soil the fingers but very little when handled.—*Dental Advertiser.*

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, July, 1887. No. 10.

MEDICAL DEPARTMENT.

SYPHILIS AS IT AFFECTS DENTISTRY.

By Wm. A. Pease, M.D., Dayton, O.

As a student I saw a considerable number of syphilitic cases; they, being young men, generally approached me, and I had the treatment of them, subject to my teacher. I also saw much of it in the hospitals in New York, and when I came to Dayton treated patients for a while, but soon refused all primarius and secondarius unless the teeth were so implicated as to make it necessary. Tertiarus were also declined that needed constitutional treatment, unless the party was from abroad, or he had become so discouraged or disgusted as to refuse to return to his physician. But, notwithstanding this, I have seen and treated a great variety of cases. By referring the cases to physicians I conciliated them, gained their confidence, and they referred cases to me requiring dental treatment. The reason for refusing to treat will be obvious on a moment's consideration. The examination by a physician is generally quite brief and without contact; but to operate on the teeth of a recent syphilitic may require minutes or hours, and the operator, although knowing the integrity of the skin of his hands is complete, and also knowing this absorbing capacity, is apt to become nervous at having them wet during a lengthy operation. It is the unconscious dentist who is happy at such times. Perhaps it was this treatment and the confidence of the physicians that has been the means of my treating many congenital and acquired defacts of the mouth, and the manufacture of such appliances as were required. It is proposed to notice a few of these typical cases that certainly belong to the specialty of dentistry; and the local and constitutional treatment of which cannot be as successfully conducted by two independent practitioners, acting without a concerted plan that is generally impracticable. Each will have an end in view and will direct his energies to the attainment of it. When urgent symptoms have disappeared the physician dismisses the patient, perhaps with the injunction to continue to take the medicine for a specified time; while the patient, disgusted with the unpalatable remedy, his digestive apparatus disordered, wholly omits; while the physician, looking to general results, is wholly ignorant of the condition of the mouth—the pulps that have inflamed and died, the periosteal, or rather peridental, complications that are present or imminent, or of the slumbering or subacute inflammation that may endanger the frame of the mouth. Even if the physician should attempt to examine the mouth of a tertiary—the secondary condition of the mouth for a time is obvious enough—he has not that trained capacity to which the daily examination of the mouth begets in a dentist, he does not know where to look for incipient trouble and he is taken by surprise.

To anticipate abnormal conditions is more important to the patient, and to prepare for them, than after the onset, is a tedious treatment. That abnormal condition that is often followed by obstinate and destructive *pyorrhœa alveolaris* would be quickly detected by a dentist, while it would be unintelligible to the physician; but it would require more than a topical treatment by a dentist, and the care of the soft and hard palate and the antrum should belong to him, especially if he is about to make an artificial appliance perfectly adapted to the parts; but the presence of which, over a smouldering volcano, may cause an eruption. Many of these cases have fallen under my observation and been aborted, that would not probably have gone to the physician until they had acquired such a momentum it would have been difficult to prevent destructive results. A case in point: About six years ago Mrs. A., æt. about forty, whose husband had been sick, his nutrition much impaired, who had decided *alopecia*, came for some operations on her teeth; as she took the chair, it being mid summer, I noticed very marked and almost confluent *psoriasis* on her arms. She said to me, "it came suddenly and nearly covered my limbs

—that her physician said it saved her from a severe sickness." The desquamation was great. After looking at her mouth I found such a condition that I declined to operate and she went to another dentist; although there was nothing urgent and I advised her that it would be better to get her blood in better condition. A year ago she returned, saying the fillings had failed, she had lost some teeth, and wished me to replace them on a plate. Her mouth was in a passable condition; she wore false hair; had had iritis, etc. The plate was made and placed in her mouth so near dark that I thought it advisable to retain it till the next day. She did not return for two weeks, but her daughter informed me she was abed with erysipelas. When she returned the plate would not go to its place, and I found a node on the median line of the hard palate as large as a pea; and glancing at her nose there were mucus patches in each nostril. By prompt action the node disappeared in a few days, and the plate was adjusted without change.

It is occasionally necessary to remove a part of the hard palate and an incision is so drawn apart by the contracting muscles it is difficult to close it, even by counter incisions through the muscles. It may be partly closed, and after scarification and suitable treatment it may be lessened or entirely closed. The bone between the eye-teeth, extending up under the base of the nose, sometimes to the antrum, but more rarely to the anterior part of the hard palate, is occasionally diseased and has to be removed.

Mr. B., æt. about thirty, was sent to me by a physician. The hard palate was dead nearly as far back as the first molar, the membrane had parted from it, and was pendent like a pouch. It was pushed back and an impression taken, a plate was fitted so as to hold it in place, and also to embrace partially the three incisor teeth, one lateral having been lost. A crucial incision was made under the lip, and after a deal of trouble, partly by cutting the dead bone into smaller pieces, it was removed from around the roots of the teeth and by reaching in and cutting, the dead palatine bone was removed without injury to nerve or artery in the anterior fossa. The plate was kept *in situ* and after between two and three months a new palate bone had been formed, and the teeth were again firm in a socket. Great care was taken to prevent injury to the roots of the teeth; and as the bone was about to enclose them they were thoroughly cleaned, so that there should be no impediment to union and no cause for a cyst. Many years after that the teeth were firm.

When, by reason of ulceration or operatioh, there is perforation through the membrane and the hard palate to the posterior nares that cannot be closed by one or more operations, by reason of size, low vitality, or other cause, the bone radiating from the perforation has sometimes lost so much vitality as to be fissured, diverging like the web of a spider; some ulceration running along the fissure, leaving deep cicatricial lines. At times a delicate instrument can be pressed between these bones, as it will in an ununited fracture. When a plate become necessary to close the perforation these fissure marks will be reproduced on it unless they are filled up on the model; then they will leave depressions under the plate that are practically sewers; as from the unhealthy membrane there is abnormally great exudation and desquamation, which will gather in them and become offensive, if not a source of ulceration, to say nothing of the mucous discharge from the posterior nares, which will get into them more or less; and disgusting as the condition is, it will make it more so. To remedy that I have sometimes run a very long, thin and flexible lancet between the bones, and so lacerated the intervening fleshy growths as to cause union. When that failed, by running a lancet along the fissure and thoroughly scarifying it; or, what is better, cut pieces of floss silk of suitable size and length, wet them in a strong solution of nitrate of silver, press them into the fissures and leave them till they have made a raw surface, when granulation will generally close them; if not entirely, repeat. Leading from these fissures into the hole to the posterior nares are often a V-shaped fissure, which can often be closed by incision or a similar application, and the defect rendered more symmetrical; and if the defect is not very large it may be closed by one or other of these processes. I have succeded in closing a hole into the antrum that would admit my finger in this way; but such successes are exceptional.

Three years ago, Mrs. H., æt. about thirty-five, was sent to me; her physician was in doubt about treatment, and discouraged her by saying she had better let it alone. There was a large fistulous opening to the antrum, through which, on pressure, about a teaspoonful of offensive matter was discharged. It was of about six years' duration. She was reticent about the cause of it, but her sister showed much acrimony against her husband, from whom she was separated, and intimated that he was the cause of it. I told her it was of so long standing, there was so much disease of the part (she was anæmic), it would be difficult to cure. A day was appointed and the whole base of the antrum was removed, and, so far as I dould ascertain, all of the diseased bone. The part was closed so as to leave it as symmetrical as possible, but with ample drainage and easy access. She was to return twice a week to have it dressed. She was put on:

℞. Potas. Iod. - - - ℥ss.
Cascara Amargo, - fl. ex.
Berberis Aquifolium, fl. ex.
Syrup Simpl. - - aa ℥i.

Sig. Dose to be increased from half a teaspoonful to a teaspoonful.

As a germicide it was syringed with a solution of borax, alternating with listerine. A pledget of cotton saturated with tinc. iod. was pressed into the cavity, followed by one either of borax or listerine, and allowed to remain until her return. The disease had advanced so far to the nose water would run through into it. In six weeks there was no perceptible discharge; she was then confined by a bad cold, and when she returned there was a slight discharge; two weeks later that ceased, but she was directed to take the medicine for a time. Have seen her frequently since and there has been no relapse and no disfigurement, caused by a suitable set of teeth.

I now come to a case that interested me much. Mrs. R., married, æt. about thirty-six. Called on me in Septemper, 1883, about her teeth; but required but one filling, which was not done; she had just returned from an Eastern summer resort. Two months later she returned, suffering from pain, and asked if it would be dangerous to extract the tooth in her condition. After the usual inquiries the tooth was extracted. Saw her again in the following July—she had lost her baby and said there was something mysterious about it. She had a quick delivery before the doctor arrived, who was a strange physician, her usual attendant living near to her. The doctor immediately took the child from the nurse and examined it thoroughly, bandaged it and put it to her breast. She was soon up and after a while had very sore nipples, and a *roscolacious* irruption over her chest. The doctor cured her, but told her she must not nurse the child; not to place her affection on it, as it would die. The child had canker of the mouth (mucous patches) and died. When she came to me I found her mouth ablaze with a secondary; she had discontinued her medicine and wanted a wash for what she considered a slight and innocent mucous inflammation; directed her to return to her doctor and so impressed her that she reluctantly did. The effect on her mouth was very persistent, but she recovered. Her absence from home was about four months; during that time her husband had probably contracted disease, gone to a strange physician and evidently supposed himself cured; he failed to contaminate his wife, who went without accident through gestation. The child was born without contaminating her, but the long-continued act of nursing diseased her nipple. She made a good recovery. The cuticular integrity of her husband saved her in the first instance, although, after the death of the child, he was under treatment for what she supposed was an innocent throat affection—tonsilitis—she called quinsy.

Another case which might have caused a conflict between doctor and dentist may be worthy of record: A married woman who was suffering from a similar mouth disease, without knowing the nature of it, was directed to have a tooth extracted. She assented and the doctor asked to whom she would go; she said to Dr. Pease; he said, "don't go to him, for he will know what the matter is in a minute—go to some young quack." She said, "I shall go to no young quack, and if Dr. Pease says the tooth ought to come out, out it will come; otherwise, not." On examination found her in the last ulcerating stage of a secondary. There were four eroding ulcers; one, as large as a dime, was so near to the tooth she wished to have extracted, there was but a line of healthy gum intervening; the palatine root was almost exposed; it was a nasty, threatening sore, and there was great probability it would bore a whole through the bone. The tooth was without a blemish except is was a little cupped, having a shining, eburnated base. It flashed upon me that he thought the bone would be diseased, that if the tooth were extracted and perforation ensue the fault would be the dentist's. I was mad. I examined the tooth and the ulcer and tried to be charitable, but the more I examined the madder I got. I determined no dentist should be a scape-goat—bear the opprobrium of having blunderingly ruined the mouth—and, without letting her know what I thought, I so impressed her with the danger of creating a fresh wound so near to such a deep ulcer, that all the doctors in Dayton could not have got that tooth out. She asked me what he meant by saying he would know what the matter was in a minute. I said he probably did not think it dangerous but thought it might be beneficial, but knew I would not extract it unnecessarily. The tooth is there yet.

A physician said to me, "I have got a good one on one of your craft," mentioning the name of a prominent practitioner. "My patient was a public woman, under treatment, giving the ordinary dose and treatment. She went to him for a small operation; he saw her gum and mouth was out of order and furnished her a mouth-wash. After some days' use she became ptyalized, and went and gave the dentist such a talk that women of her class are capable of. She then saw me and complained of him. I directed to discontinue the wash and my medicine and to resume mine after a few days." By a practical silence that was very suggestive he escaped at the expense of the dentist. Knowledge is sometimes power; at others, a detriment. It is not probable many patients are sent by their doctors to young quacks for fear it will detect their condition, as the secrets of the confessional are sacred, though it lessens self-esteem to be detected or to have to confess.

But while writing of confession, I wish to confess and cry *peccavi*. A gentlemen of much importance to the community came for an upper denture, his mouth being ready; examination for the hard and spongy places disclosed considerable periosteal tenderness over a part of the hard palate; the soft palate, uvula, and pharynx did not attract attention. My experience in such cases made it my duty to tell him that a plate, in the condition of his mouth, might cause him trouble. He replied to questions that his teeth were sound, the pulps died, ulceration supervened, they had to be extracted; other symptoms were disclosed, and he finally said he contracted a sore in St. Louis that caused no trouble, was thought to be an abrasion, and soon healed without consulting a doctor. He had an excellent constitution, escaped the ordinary secondaries, and did not know the loss of his teeth, etc., were significant. Years before a friend, seeking a location in a warmer climate, spent some time in Alabama and Georgia, and became convinced the Indians had some specific for syphilis. When Swift's specific and his Indian came out I hoped he had got the remedy—the more so as a friend, thoroughly treated, had the fistulas at the head of his humorus, who, after a course at the Hot Springs, commenced while in the South with S. S. S., and the fistulas were healed. He said he felt strong and well and was full of courage. I asked him if the parboiling by cleansing his skin, etc., might not be the cause. My patient was put on S. S. S., though it was put into another bottle, and he soon began to feel better, and was more buoyant and hopeful. After taking five bottles (large) he was still hopeful—encouraged—the disease was not cured but held in check. To continue: About that time Sim's formula was published in the *Cutaneous and Syphilitic Journal*, which encouraged me, and I put another patient, who had exhausted the mixed treatment, on S. S. S. He also felt better and was hopeful. The first patient, after taking nine bottles, was not cured; and neither the second after taking five, but the stomach of the first began to rebel. As every bottle had a request on the label for parties in doubt to write to two physicians in the office, who would give instructions; and having heard much of Southern honor I innocently thought they meant business; had confidence in the preparation. So I wrote and gave a brief account of the patient, what he had taken, and honestly stated he was a patient of mine, and asked if the case was exceptional; whether I should continue the S. S. S. or quietly drop it. The answer was on small note paper, in a coarse, scrawling, young school-boy's hand, and of about these lines. It stated that the S. S. S. was entirely vegetable and would hurt no one, probably in reference to the stomach irritation I referred to. Only that and nothing more. Did I not feel cheap? The first patient was then put on:

℞. Hydrarge chlor. cor. gr. i.
Potass. Iodide - - - ʒv.
Syrup Simple
Aqua - - - - - - aa ℥ii.

M. sig. A teaspoonful in a glass of water, after meals, three times a day.

The other took iod. potass. in a tonic vehicle, and both eventually got their teeth. The patient whose humorus had healed continued to take the S. S. S. bottle after bottle, but at length became doubtful, months after swelling supervened, was lanced, and the last stage was worse than the first. I also tried J. Marion Sim's formula; it is doubtless similar in essentials with S. S. S.; they have some tonicity; possibly are alterative, but were useless in my hands, and Sim's preparation is not on the market. Have made inquiries and have heard of no cure by either of them. I have not succeeded any better with the trifolium compound and have become tired of experimentation.

Two parents of this city took such a child under the age of puberty, each to a dentist abroad, expecting to get better skill.

Neither one of those dentists would be rated second-class here. Soon both of the children had sores in the mouth, which were neglected until the children became quite sick. Probably owing to the age, the cases were not thought to be serious, or by the attendants to be specific until too late ; both of the children died.

Two women went to a popular dentist of this city, about the same time, to have teeth extracted; both had sores in the mouth soon after, and became sick. One of them called in her physician, and after a while another in consultation, and finally on me. My diagnosis was specific. She had been treated for blood-poison, but on change she became better in the spring, after having suffered much in the winter. She went East for change of air and the doctor there concurred with me. I lost sight of the other.

For more than thirty years there has been in my office a large, wide-mouthed fruit-jar, containing a germicide and disinfecting solution, into which all instruments were placed that had been in any suspicious mouth, and my hands have been as regularly disinfected. It is well known that physicians sometimes contract disease by digital examination, and other men do by digital fooling with women, and sometimes they get a club-ended finger or other deformity to pay for it. Some dentists have considerable practice with women of the town and do not seem to suffer from it; and it is not known that they take unusual precautions ; but as Mrs. R. escaped disease from her husband, there being no breach of continuity or weak cicatrix on him, it is evident that cuticular and mucous membrane integrity are bars to it, after the chancre has healed ; that, long after that, it may be given to a child at conception ; and ten months after that be communicated to the breast by means of contact with a sore mouth.

It is the history of these and other cases that has made me pause. Of course, there are many contaminated persons capable of giving disease whose mouths give no indication of it; and there may and may not be other recognizable indications. Treatment may cut short the period of communicating, but Mr. R. had probably gone through a thorough course of treatment—doubtless the mixed—his system still saturated with the remedy used when he begot the syphilitic child that, ten months after, diseased its mother by her nipple absorbing the virus from a constitutional sore in its mouth. Its system was then full of it, and along with the specific matter that contaminated it there ought to have gone, *pari* *passu*, the constitutional remedies used by its father and neutralized or destroyed the infecting matter.

Measured by this case, a tertiary lesion in the mouth should be capable, under favorable circumstances, of conveying the disease. The blood, so thoroughly infected as to create a sore, carries all the elements to the secretion or exudation of that sore necessary for the initiation of a chancre on a susceptible surface. Where there are condiloma or mucous patches there is activity and danger. *Timeo danaos et dona ferentes.* I fear such patients, even though they bring fees. But fear should be based on knowledge; in some of these cases there is an element of doubt. Dentists should not assume, they should know, or have that experience that approximates to knowledge. Because they find irritated or infiltrated fauces, stomachaic sores in the mouth they should not be suspicious. There are more innocent than noxious sores. And it is sometimes not easy to discriminate between a light or grey exudation—a kind of scab that protects an irritated spot from the air or contents of the mouth—and dead mucous membrane detached from its base, which is generally lighter, often running in horizontal lines across the soft palate, but sufficiently near to make an experienced man pause. I have written nothing of syphilodermas and various other outgrowths of the poison, although familiarity with them makes diagnosis sure. This paper is already too long to consider heredity as exhibited on the teeth and mouth, and the terrible tales they tell to the experienced eye; or to consider them in relation to Hutchinson's teeth, which has engaged my attention for thirty years; nor can I notice the effects on the children of many men as they have successively appeared during nearly forty years—men who never should have married and who have paid a terrible penalty for having so done.

I have generally avoided, for obvious reasons, the usual technical terms.

All the Cincinnati medical societies have adjourned until September.

ABSTRACTS.

THE TREATMENT OF PLACENTA PRÆVIA.

By J. BRAXTON HICKS, in *The London Lancet.*

SIRS, –I suppose, strictly speaking, that no particular method of managing placenta prævia can claim being *the treatment*, because the conditions which present themselves when we are called to these cases vary very much, and to each variety there is a more appropriate treatment. Besides the two positions of the surroundings I mentioned in my last letter—namely, where we are called without previous knowledge, and secondly, where we have already ascertained the existence of placenta prævia,—there are three main classes:

1. If the os uteri be well dilated, the placenta extending but a little over the os, and consequently the membranes plainly felt, the rupture of the membranes is the first thing to be done. If turning has been determined upon, then this will be performed at the same time; otherwise we might wait for the natural forces. Should these hesitate, or hemorrhage continue, ergot, forceps, or version should be employed, according to circumstances. There will be no reason to detach the lower portion of the placenta.

2. Should the placenta, however, be attached nearly or entirely athwart the os uteri, then the detachment of the placenta as far as the fingers can easily reach will have a twofold effect: it will relieve the os from the restriction the adhesion of the placenta caused, and permit consequently its expansion; and it will also for a certain period generally check the bleeding, but not always; sometimes there is a very sharp loss; then the quickest and surest plan is to turn at once and plug the os by the leg or breech; the bleeding then stops, and pains generally arrive in a short period. If, after this separation of the lower portion of the placenta, no bleeding arise, and if we can remain about the patient, the natural forces might be trusted to deliver the patient; should, however, these hesitate, we might elect two plans—either to dilate the os with Barnes' bags, and when the os is large enough to apply the forceps to the head to bring this into the os, or turn and bring the

breech into the position. In either case labor pains usually soon come on. We should keep on the forceps, however, to assist, if needful, till the head is clear. But if, on the contrary, we have neither bags nor forceps at hand, then version by my method gives the patient security.

3. But supposing the os uteri is small, the bleeding severe, and, called on suddenly, we are unable to obtain either dilating bags or forceps, also unable to leave the patient till delivered; then it is (now that the tampon is for ever, I hope, discarded), even though the os would admit only one or two fingers, that my plan of turning becomes the security of the patient, and being the only treatment possible, and of the most secure kind, it does practically become *the* treatment.

In the second class of cases, when the employment of version becomes necessary from the continuance of hemorrhage, and both dilators and forceps are absent, and the os being not dilated sufficiently to admit the hand, then my plan of turning becomes *the* treatment, and the patient's security, and, except the *accouchement forcee*, the only security; and these cases, coupled with the third class, form by far the largest number in every-day proctice. But the full recognition of the rule for as early a delivery as possible in cases of placenta prævia brings out the advantage which the capability of early version given us by the combined or bipolar method, advancing treatment a considerable stage earlier; and when other methods are not to hand, as I pointed out in 1863–4 in my remarks on Dr. Greenhalgh's paper, and in my work on Combined Turning, there is one advantage in this form of version, that soon after the leg is brought through the os uteri labor pains generally occur, giving time enough for the patient to rally and an early release of the medical attendant. Dr. Lomer points out the ease with which his assistants learnt it, and he thinks they represent very well the average in the profession, the cases reported having been done principally by them. Still, without classifying the employment of version as a routine, practice gives results at present of the most favorable kind. In the conclusion of an unavoidably egotistical letter, I would again urge those engaged in midwifery, while employing all the modern methods of help suitable to each case, to remember the rule, "Deliver as early as possible after the recognition that the placenta is about or athwart the mouth of the womb;" and to this I would add, "Don't leave the patient till she is delivered." As the result of my experience, I have often remarked I would rather handle a case of placenta prævia than one of post-partum hemorrhage.

George-street, Hanover-square,
April 3rd, 1887.

MYXO-SARCOMA.—A milliner, aged eighteen, a blonde, apparently in the enjoyment of excellent health, was admitted into Regent ward on January 13th, 1880, for a swelling of the left knee joint, latterly accompanied with so much pain as to render walking very difficult. The swelling was about the size of a pigeon's egg; it was firm, yet somewhat elastic; its consistence suggested that it might be a very tightly distended cyst. When the leg was extended, the swelling seemed fixed to the femur, just above and slightly behind the external condyle; but when the leg was flexed a distinct mobility of the swelling upon the femur was recognizable. It was in close relation to the tendon of the biceps muscle, which passed behind and internal to it. The patient stated that about four years previously she first began to suffer in pain in the knee, which was regarded as rheumatic; the pain gradually increased, and this latterly to such an extent that the limb was nearly disabled. The swelling was first noticed about one year before she entered the hospital. The diagnosis was a gaeglion connected with the bicipital sheath, tightly distended. A few days later the swelling was exposed and dissected out. Its rough characters were those of multilocular cyst, the spaces of which were filled by a jelly-like substance. The wound healed well, and the patient went home on February 26th.

On August 26th, 1881, being about nineteen months after the first operation, the patient again sought admission into the hospital. A note of her condition at this time states that there was at the outer and posterior aspect of the knee a subglobular nodular swelling, three inches in diameter, crossed by the scar of the former operation. Its consistence was not uniform, being mostly firm, but in some situations so soft and elastic as to occasion the idea of fluctuation. The mass was plainly now attached to the femur. The patient was unable to fix the date of the reappearance of the tumor, but she thought that it was not very long after she left the hospital. She attached so little importance to it that it did not deter her from marrying. Amputation was proposed by Mr. A. Clark, then in charge of Mr. Hulke's ward, but it was declined by the patient, who left the hospital.

On November 4th following the patient returned, looking thin, anxious, and worn. The tumor had in the interim considerably increased. The limb was removed by a circular amputation at the middle of the thigh. The femoral artery was secured by torsion. The stump suppurated and healed slowly, so that she did not leave her bed until January 4, 1882. At the middle of the month she was allowed to return home, having gained flesh, and feeling stronger and looking much better than before the amputation. The tumor proved to be a myxo-sarcoma, springing apparently from the periosteum of the outer condyle of the femur. The preparation is preserved in the Middlesex Hospital museum, No. 544, catalogue.

The patient was not seen again until the autumn of 1885, when she entered a medical ward for intense dyspnœa, under the care of Dr. Cayley, who referred it to sarcomatous infiltration of the lung.

Death occurred suddenly. At the necropsy, Dr. Fowler found the upper lobe of right lung compressed by a sarcomatous mass, a portion of which intruded into the right bronchus. From this a detached nodule of the size of a walnut had escaped into the trachea and caused suffocation. The middle lobe of the right and the lower lobe of the left lung each contained a small knob of tumor. Its histology was that of spindle-cell sarcoma.—*London Lancet.*

NERVOUSNESS IN WOMEN.—Prof. Bigelow, in *Lancet*, May 7, 1887, speaking of the "Psychic and Nervous Influences in Diseases of Women," says:

In losing sight of constitutional causes as factors of local disease all special erudition and all clever handiwork will be in vain. Many ills to which women are liable are merely *symptoms*, and they will never cease their direful work until intelligence looks deeper and attacks the exciting cause. It will not be one particle of service to attack a retroverted uterus with pessaries (a refinement of torture and of unscientific deduction of this nineteenth century) in a highly nervous women, whose trouble rests not with her womb, but with her "run down" condition generally. I will go a step further, and assert that rest, good diet and regular, electricity, massage, and Turkish bathing (when indicated), with wholesome psychic surroundings, will, in very many instances which receive nowadays only local attention, accomplish more permanent and real good than any special interference. Vastly more harm than good has resulted from the happy-go-lucky way of applying pessaries, and quite as much evil comes from the brusque way we have of relegating all womanly suffering to pelvic derangement, and then rushing blindly at that, irrespective of the shock we may occasion to a highly modest and sensitive woman. Liebermeister asserts that this *nervositat* is due to a disease of the grey substance of the brain which depends upon a derangement of the lower brain function, as contra-distinguished from the true disease of the brain, which is due to a disturbance of the higher psychic function. Convinced in my own mind that Liebermeister is right, I should seek to improve every detail of the woman's environment, subjective and objective, before resorting to local interference; of course I mean in those instances in which the local trouble is purely secondary. "Run down" women, women with all sorts of anomalous aches and pains, women given to morbid introspection although they *may* have some pelvic pathological condition, demand first constitutional handling, and we simply intensify every bad symptom by ambitious specialism. Rheinstaedter says: "I have never yet done a castration for *nervositat*, and I intend never doing so in the future. How can we hope to cure a brain disease through castration? Why do we not castrate men for nervousness?" The radical operation of oöphorectomy in case of neurasthenic hysteria (and I mean by this an hysteria which is clearly due to nerve exhaustion) is *never* indicated, neither can it ever be indicated in pure neurasthenia. In pure hysteria it is only justifiable when the exciting cause can be clearly and absolutely located in the ovary beyond all question of a reasonable doubt, and even then it should never be thought of until we have exhausted all the means of conservative treatment which recent investigation has placed within our reach. It seems to me that the clear indications for so dangerous an oderation are so very small as to be almost *nil*, and I am convinced that many cases on record so operated upon would have gone on to a wholesome recovery under strict conservative treatment, as we realize and recognize it to-day—a treatment that requires boundless patience both from patient and physician, but which accomplishes its purpose surely and almost insensibly to the woman, until she finds herself carrying out the daily duties of life as most women do, and with the same measure of comfort. A woman's mind has much to do with her general condition, and herein lies the secret of the rest treatment. With a mind at absolute rest, with no thought of the morrow to conjure up the fiend of ways and means, with a complete realization of the *dolce far niente*, we have at hand a more potent medicine than any sent out from drug stores. And I know, because what I have seen I believe, that under such rational handling many gynæcological cases go on to recovery without any local interference. Of very especial value is rest treatment, because it enables the physician to discipline the disorganized will, and to bring it into harmonious relationship with the other bodily functions. Hysteria disappears at once under an organized, well-sustained moral discipline. The nervous condition, which is the underlying cause, is one of exaggeration, congestion and exhaustion, and these all disappear upon proper hygienic observances, conjoined to will training. The weakened will itself is but part and parcel of the whole nervous disorganization, and will regain its normal standard as soon as the other functions return to a physiological basis.

ASPIRATION OF THE URINARY BLADDER—By A. Wilkinson, M.D.

Having seen Mr. G. Buckston Browne's letter in your issue of Feb. 29th, also the report of and discussion on a paper read by Mr. W. H. Bennett at a recent meeting of the Medical and Chirurgical Society on a case of rupture of the urinary bladder which terminated fatally as a direct result of aspiration above the pubes, I am induced to send you the notes of a case in which the bladder was aspirated by this method sixty-nine times in immediate succession by myself and assistant alternately.

The patient, a large fat man, aged sixty-seven, had been an invalid three years owing to brain mischief, and during that time was gradually getting worse. His intellect was so far impaired that none of his statements could be credited, but, as far as could be ascertained, he had had some difficulty in micturition, but no actual retention till till September 3d, 1885. the date of my first visit. The history, condition, and symptoms—aphasia and paresis—pointed to cerebro-spinal disease; but an enlarged prostate, fully the size of a tennis-ball, undergoing some active change, probably inflammatory, was the immediate cause of the retention. The bladder was greatly distended, and the urethral passage narrow, tortuous and painful. With considerable difficulty a No. 5 gum-elastic catheter was passed, and about thirty ounces of urine drawn off. This was repeated on the fourth and again on the fifth, but from the latter date to October 16th, as no catheter could be passed, supra-pubic aspiration was resorted to, sometimes once a day, more often twice. The punctures were made with a fine needle corresponding in size to No. 19 wire. The natural route to the bladder was still occluded, and aspiration having been performed fifty-four times, on October 16th I punctured above the pubes with Pearce's trocar and canula with the view to establish a permanent outlet. The canula was tied in, but owing to the patient's interference, he twice pulling it out, that course was abandoned. The aspirator was again brought into use, and continued until the 25th, when I succeeded in passing a No. 3 soft catheter, to which an exhauster was atttached, and the urine drawn off. The catheter was tied in, but removed by the patient in his demented condition. On the morning of the 27th about a teaspoonful of pus suddenly gushed from the urethra, and on passing the catheter about four ounces came through it, fairly conclusive that prostatic abscess had been the cause of the retention. Catheters gradually increasing in size were passed from day to day, until No. 10 could be easily introduced even by the patient's attendant. In this case the urinary bladder was aspirated above the pubes sixty-nine times in succession. All the punctures were made within an area about the size of a crown-piece, the most recent being as far removed as possible from the previous one. Small subcutaneous shot-like induration followed the punctures, but soon disappeared, leaving no ill-effects. The urine, which at no time contained sugar, after three or four aspirations became excessively large in quantity, being secreted at the rate of five ounces an hour, often more, and subsided to its normal amount when the aspirations were discontinued. The patient residing at a distance of nearly four miles, and the urine being so large in quantity, over-distension was not an unfrequent occurrence, but notwithstanding this unfavorable circumstance the bladder maintained its own fairly well throughout, the urine only becoming turbid toward the last. The patient so far recovered that his attendant was enabled to relieve him by a soft catheter when necessary.—*London Lancet.*

STARCHY FOOD FOR INFANTS.—*The Lancet* report of Medical Society of London contains the following paper:

Mr. R. W. Parker read a paper on the alleged Dangers of Starch-containing Foods during the period of Infancy. As the result of many years' observation at the East London Hospital for Children and in private practice, but stated his belief that the dangers of starch foods were greatly exaggerated. He was quite aware of the mortality among artificially-fed children, but he attributed this, as well as the marasmic condition of many that did not actually die, to congenital debility, the result of debilitating influences of various kinds acting on the parents before the birth of the children. An analysis of cases had convinced him that; in a large proportion of cases, artificial food was only commenced because the childrnn were weak and puny, and not thriving on the breast milk. Mr. Parker did not advocate artificial feeding, nevertheless, but the contrary. He rather implied a belief that artificial feeding was on the increase, and that it had the consent of the medical profession: many mothers left off suckling, he argued, without sufficiently good grounds, so widespread was the doctrine that if all the starch had been converted into dextrose, and so rendered digestible, artificial feeding might safely be commenced. This was quite an error, and, moreover, it was desirable that mothers should nurse their children, as nursing mothers were less liable to conceive, and thus there was a longer interval between the childbed. Too rapid child-bearing was one result of not suckling; it was very debilitating, and one of the most potent sources of the marasmus and weakliness so largely present among the children of the poorer classes. Besides this, a child that was deprived of the mother's milk was probably deprived of the mother's care, not less important than the milk for a weakly child. Thus, Mr. Parker argued, there were many factors to be taken into consideration in estimating the causes of marasmus and its consequences. He thought that too much stress had hitherto been laid on the effects of artificial feeding, and more especially on the starch constituents of this food, and that too little stress was laid on the congenital debility of children born under adverse circumstances.

CREMATION IN CINCINNATI.—The new Cincinnati Crematory has been tried and works admirably well. There is no longer need to contaminate the soil, water and air with decomposing dead, for they can be cremated with neatnes and celerity. Death will be robbed of half its sting when we know our bodies are not to become food for worms.

EDITORIAL.

A. B. THRASHER, A.M., M.D., Editor.

THE INTERNATIONAL MEDICAL CONGRESS.

Gradually all factions are coming together, and a harmonious session is now assured. The physicians who thought that the Congress would be a failure without the prestige of their names and the benefit of their intellects have doubtless begun to realize that they are not of so much importance as they had supposed. American physicians are too numerous and too intelligent to suffer a great enterprise like this to fail for the want of the co-operation of a few gentlemen, however renowned and scholarly this few may be.

The papers offered to the different sections are numerous and the authors are men of distinction.

The prospect is fair for a very large attendance of distinguished foreign gentlemen, and they will surely be met by a still larger number of distinguished American physicians.

THE PHYSICIAN'S VACATION.—Why should not physicians take a yearly vacation? Not necessarily in the summer, for with some this is the busy season of the year. But once a year a vacation, a change of scene and occupation, will act like a magic tonic to most hard worked doctors, and their work for the rest of the year will be the better done. Don't be afraid to go away for a week or a month and leave your practice in the hands of some struggling young doctor who will be as much benefitted by the work as you will be by the rest.

WONDERFUL! In the *Homœopathic Recorder* of May are reported two wonderful cases: I. Nasal polypi completely removed in four weeks by 30 powders of milk sugar, 3 of which contained calc. carb.; one powder every morning. An eminent surgeon had operated on the polypi six weeks before, but the innocent editor attributes the cure to the sac., lac. and calc. carb.

II. Arnica oil was rubbed on a swollen knee, and "six weeks of this treatment produced a fine luxuriant growth of hair on the skin in which the oil had been rubbed."

BOOK REVIEWS.

PAMPHLETS RECEIVED.

ANÆMIA. By FREDERICK P. HENRY, M.D., Professor of Clinical Medicine in the Philadelphia Polyclinic, etc., etc. Reprint from THE POLYCLINIC. Philadelphia: P. Blakiston, Son & Co. Cincinnati; Robert Clarke & Co., 1887. Price 75 cents.

This neat little monograph of 136 pages is a very interesting *resume* of what is known on the subject.

◆

A DAKOTA DOCTOR.—The Board of Health of Dakota publishes the results of an examination of an applicant for a license to practice medicine. He had been practicing medicine for years in a populous district of South Dakota. Here are some questions and answers:

Question. What medical journal do you take, doctor? Answer. Well, they have all run out.

Q. Don't you intend to take any of them again? A. Well, I can get along without them.

Q. What books have you in your library? A. "Gunn's Family Physician and Common Sense Home Doctor."

Q. What is an element? A. Oh! anything.

Q. Is that bed an element? A. Yes.

Q. Name the three great cavities of the body. A. The head, the belly, and the diaphragm.

Q. Mention the contents of the cranium. A. The brain and three skins.

Q. Name contents of abdominal cavity. A. Kidneys and the prostate gland.

Q. Does the prostate gland ever become enlarged. A? Yes.

Q. Have you treated any cases of enlarged prostate? A. Lots of them.

Q. With what success? A. Tip-top! Never lost a case.

Q. Did you ever treat any female for enlarged prostate. A. Oh, yes; numbers of them.—*N. Y. Medical Record.*

THE

CINCINNATI

Medical and Dental

JOURNAL.

Vol. II. Cincinnati, July, 1887. No. 10.

DENTAL DEPARTMENT.

ON REGULATING TEETH.

REPORT OF PROCEEDINGS OF NEW YORK ODONTOLOGICAL SOCIETY.

[From *Dental Cosmos.*]

Dr. N. W. Kingsley. In regard to appliances for regulating, I am reminded of a query that was put to me once by a young man: "What kind of a fixture do you use now for regulating teeth?" I cannot regulate teeth with any one fixture. Some variation of an old appliance must be invented for almost every case. I once started out with the idea—it seems idiotic as I think of it now—that I could publish descriptions of a sufficient number of cases to cover the whole ground of regulating, enabling anyone who came after me to hunt up the particular case that met his need and he would find the treatment fully described. But the more I went into it the more hopeless the task became. It is simply impossible, impossible! Some of the appliances that will do well for me in my cases and with my habits would not serve another as well. Dr. Jackson spoke of a cuspid that was shutting inside of the lower teeth three weeks ago, in the mouth of a patient over thirty years of age, and which to-night is out in place. I am glad it is. Some people would have taken six months to get it out. I have seen the same thing done in seven days with a jack-screw. I do not know that there is any objection to doing it rapidly. I would use the jack-screw, and if there was room for the tooth to come into place that would drive it out in short order. The explanation of that rapid moving of a tooth is that the alveolar process gives way. There is no absorption in such cases on the outside, nor any deposit within the socket, in so short a time as that. The thin alveolar process is forced out, and the tooth being retained in its new position, the space behind will be filled up again. I have done that several times, and I do not see any objection to it.

Dr. Hodson. How many days did you say it took in the case you spoke of?

Dr. Kingsley. I did it once in seven days for a patient thirty years of age.

The President. I would like to ask Dr. Kingsley's opinion regarding those models which were presented at the last meeting from Dr. Colignon, of Paris. The question then arose whether there had been a "jumping of the bite."

Dr. Kingsley. There is no question about it. It is evident enough to my eye that the bite has been jumped. "Jumping the bite" is one of the simplest things that I know of. Many of the irregularities that we have to deal with result simply from the pinching-in of the upper jaw at the sides, throwing the lower teeth just one tooth further back than they would otherwise be, and giving the appearance of great prominence in front. If the upper jaw in such a case is spread a little, the bite will be jumped forward and the whole difficulty is corrected. For spreading a jaw under such circumstances as that I prefer a jack-screw. I have tried Coffin plates, with which the jaw can be spread, to be sure, but the work is not done with that positiveness which attends the use of the jack-screw, nor is it none as quickly.

Dr. Williams. Has Dr. Kingsley ever seen any cases of the devitalization of teeth resulting from the rapid moving that he speaks of?

Dr. Kingsley. I do like occasionally to come before a body and acknowledge failures. There is a sort of satisfaction in it. But to tell the truth, I do not know that I have ever destroyed the vitality of the pulp of any tooth that I have treated for irregularity. It may have occurred, but such a case never came to my knowledge. I have seen such a result, and have been told by the patient that it had followed the treatment for irregularity by some dentist, but I do not know whether it was true or not. I have at times trembled with fear that a tooth that I was so treating would drop out before my eyes, so loose have I seen them, but as yet I have been spared that misfortune.

Dr. Williams. Early in my practice I saw some cases of devitalization of pulps from too great rapidity in moving teeth. One case that I remember was due to the persistency of the patient in bearing pain for the sake of facilitating the regulation; the result was a devitalized central incisor.

Dr. W. H. Dwinelle. I can give some little testimony in regard to regulating teeth, having had considerable experience with that branch of the art; and I have had some extreme cases. I remember a lady, between forty and fifty years of age, whose right superior cuspid was so far within the arch that it interfered materially with her articulation; it was almost in the center of her mouth. I brought it out into line in six weeks. There was a great deal of solid material to break through in order to bring the tooth into place. I used the steel jack-screw, which instrument I had the pleasure of introducing to the profession many years ago. There was no devitalization of the pulp, although the movement was comparatively rapid; neither have I ever known a case of devitalization resulting from the use of such a fixture. I would like here to add my testimony to that of Dr. Kingsley and others in reference to the action of jack-screws. I think it is preferable to all other means of moving teeth, and the effect of it is comparatively harmless. It is positive and direct. Instead of depending upon the elasticity of the fixture, as was mostly the case before the introduction of the jack-screw, we depend upon the elasticity of the tooth and the alveolar process; they are elastic, and we use a direct and positive instrument which has no elasticity and forces the parts apart with comparative impunity. A fixture with an irregular pressure or tension will cause more inflammation. It is the wiggling of the teeth and the vibration backwards and forwards that causes the most irritation. We all know that when a sensitive tooth is grasped in the fingers or wedged firmly to its place while being filled, the pain attending the operation is greatly relieved. The jack-screw is positive in its action; you may screw it up to the utmost bearable point, and in a few minutes the pain passes away, while the process of regulating advances with great rapidity.

Dr. Williams. In regard to the force exerted by the jack-screw, there is another idea involved. The jack-screw gives a certain pressure, and then the tissues have a chance to rest. It is continuous pressure, like that of rubber bands, that causes irritation and devitalization; too continuous effort of any kind brings exhaustion. Alternate exercise and rest is the principle of health; and the use of the jack-screw implies that.

Dr. F. Y. Clark. I have heard within the last few months a great deal in regard to regulating teeth. At the great meeting held in this city some months ago much was shown and said upon the subject, and if one were to believe one-half of it he might truly say the whole thing is simple and easy. But it was very evident to the experienced practical mind that all was not quite as represented. There was a great deal of *impractical theory and machinery*, but—and the omission was quite noticeable—no failures were reported. I am of the opinion that we don't hear all the truth. The trials and difficulties are smothered and kept back, while the successes are shown. Dr. Farrar, with his complicated network of springs and pullies, has no failures. Dr. Talbot, with piano-wire springs, is equally successful. Dr. Kingsley, who ignores and condems both, is all right; and Dr. Jackson, who apparently does all with split plates, speaks of but one single failure. But somehow or other in office practice we now and then see cases from the hands of able and prominent dentists which *are failures*, and occasionally *very bad ones*. Were it not for this, we would, after all we have lately seen and heard, feel disheartened, and be inclined to think that after a life-long practice we are yet in an embryonic state.

According to my own experience, the most important point on this subject is the control of the patient. Sometimes when a difficult case is well under way the parents' sympathy overcomes their judgement, and the child either does not put in an appearance, or comes with the apparatus in his pocket, where perhaps it has been for some time. Now, to guard against this and kindred evils, I know of no better way than to insist upon the payment of one-half the entire fee in advance. This is a dental retaining fee, and in the majority of cases gives wonderful control of the patient. This is a valuable rule, and it works well for both patient and dentist. A few patients may object at first, but when informed that the rule is enforced in every case they will give way, and in the end be better satisfied. I have just finished a difficult and tedious case,—that of a gentleman of position and prominence, over thirty years of age, whose superior teeth—with the exception of the two centrals—closed far inside the lower ones, giving a deep, squirrel-shaped arch, and leaving so little room for the tongue that articulation was materially interfered with. The teeth were very firm, and it did not seem as though it was possible to move them. But the patient was anxious and liberal, so the controlling or retaining fee of four hundred dollars was paid about one year ago, when the models were taken. The case was finished to-day, and I may safely add that both patient and operator are well pleased. Although this was one of the patients in all respects, I am rather inclined to believe that at one time the case would have resulted in failure had it not been for the money anchor, which—thanks to its strength—held fast.

We know Dr. Kingsley is authority on this subject, and as he has lately done some good work in bringing to view the errors or sins of others, he ought to willingly bear a little rasping himself. It don't hurt him. Now, I do not intend to say he did not move that cuspid in the mouth of a patient thirty years old in seven days, but if he did he moved it about a quarter of an inch.

Dr. Kingsley. I don't think it was half that distance.

Dr. Clark. At any rate, it was pretty rapid work, and no doubt safe with Dr. Kingsley; but were I to attempt it devitalization of the pulp or something worse would be pretty sure to follow. In the case to which I referred a moment ago I could do nothing with the strongest piano-wire. It would not even start the teeth, and after many trials of similar appliances with little or no result jack-screws were used.

The President. I hope we may have the pleasure of seeing the models of this case at a future meeting.

Dr. Weld. I would like to ask the gentleman if he received his other four hundred dollars?

Dr. Clark. Most certainly. I have a check for it. If we would add a figure or two to our usual charges for some of these regulating cases we would not be overpaid. We rarely get paid for the time spent on them if the time is valued as for other operations.

Dr. Weld. I have listened very attentively to Dr. Jackson's paper, and I think we are under obligations to him, both for the paper and the exhibition of models. The appliances shown certainly reflect great credit upon him. Success in such operations is due, first, to the ingenuity and perseverance of the dentist, and secondly, as has been correctly observed, to the proper control of the patient. I think the measure of success in all these cases is about in proportion to those three conditions or requisites. Nevertheless, if Dr. Jackson were to read another paper and exhibit other models, say in two or three years from now, for each individual case he would have a different appliance. It simply bears out what Dr. Kingsley said, that there can be no one set of fixtures nor any one principle by which teeth can be regulated. In every individual case we find a different state of affairs, and we are obliged to adopt different appliances and different treatment, whether by the positive method or by the use of springs.

The President. Dr. Dwinelle can possibly tell us something about the old method of regulating teeth suddenly with the forceps. While on the subject of rapidity of movement, I may mention that I once threw the upper teeth outside of the lower ones in fourteen days, for a young lady twenty-eight years of age. As she was about to be married she lost no time in completing our operation.

Dr. Dwinelle. I have known Dr. John Allen, of this city, to regulate teeth for young children with the forceps. He had forceps made for the purpose. The alveolar process was broken up and the teeth regulated immediately. There was no destruction of the teeth or the parts, and no unhappy results followed.

I wish to say a word concerning the reference made by Dr. Clark to getting, no matter how, the coöperation of the patient. He does it by making it for their pecuniary interest to coöperate. We all know how often we might have succeeded had it not been for the caprice of the patient or their parents or friends. If Dr. Clarke has devised a method by which he can get the coöperation of his patients, I think he has made a large contribution to-night to dentistry.

Dentists are, and necessarily must be, an army of inventors from morning till night. I might almost say that we never do a thing twice in the same manner. We realize the force of the old adage that necessity is the mother of invention, and by stress of necessity we are constantly getting into corners and difficult places where we are stimulated and inspired, so to speak, to invent our way out by new devices.

Mr. President, I take great pleasure in introducing to you and to our society Dr. Adair, of Gainesville, Georgia. Dr. Adair is a graduate of the Baltimore College, class of 1874, I believe. He is engaged in developing the New South, a work with which we of the North heartily sympathize.

Dr. R. B. Adair. Mr. President and Gentlemen of the Odontological Society: It affords me great pleasure to have the honor and privilege of being present at one of your meetings. Although I came here to listen and learn, and not with the expectation of making any remarks, it has delighted me to be able to look upon the faces of men whom I have been following for twelve or fifteen years, and with whom the literature of our profession has made me somewhat acquainted. I started out about two months ago upon a tour of investigation, seeking information from all sources. I came from the Sunny South, as has been intimated; went around by the West, and I am now in the East seeking light.

Dr. J. Morgan Howe. I have been interested in the paper and models presented by Dr. Jackson, and feel like complimenting him on the success of his operations. He has attained success in these cases by a method which I have not ordinarily pursued. But results are what we look for, and Dr. Jackson has certainly presented excellent results. There is only one criticism that I would make, which is in the line of some remarks which I made at the last meeting,—that a fixture, especially one for retaining, is liable to injure the teeth when made of metal, and is in that condition of semi-contact with the teeth that all removable fixtures, such as shown, must be in. A little lack of cleanliness, which is almost certain to happen, will result in injury to underlying enamel, and I think this liability to injury is lessened when only non-metallic substances, non-conductors like vulcanite, are against the teeth; so I would question the propriety of such wire retaining fixtures as Dr. Jackson has shown.

Dr. Jackson. I am sorry that this subject has not been considered in a different manner. If, upon examination of the casts, any more practical method of accomplishing the same result in these cases had suggested itself to the gentlemen, it should have been stated. The best and most practical methods of regulating teeth are what we are seeking for. The majority of these patients are young, and it would be impossible to use a jack-screw in the mouth of a patient nine years old without meeting with a good deal of resistance on his part, and much trouble. None of my little patients hesitate to come at any time. The appliance I use is one of the most simple that I can conceive of for spreading the arch and regulating the teeth. Intermittent pressure has been referred to as analogous to the law of nature. The law of nature is that pressure and relief alternated cause hypertrophy, increased growth, hardening, and constant pressure causes atrophy or absorption. If you want absorption you must keep up a constant preasure without intermission or rest. We do want absorption in cases of regulating. Regulating has with me been made easy. I have no trouble with my patients, have never had one stay away because the fixtures hurt, and all my cases thus far have been carried to completion. I have used jack-screws, but do not now, for I do not want to make my patients so uncomfortable.

Dr. Clark. What would you do if you used the strongest piano-wire you could get, and yet could not start the tooth?

Dr. Jackson. I should certainly use two of them. Here are models of a case where I attempted to move a tooth with the ordinary screw in a plate, and I did not succeed. Then I put on a jack-screw, and that did not make the tooth move until it had driven three or four others out of place. The patient was about twenty-one years old. To-day, if I should be called upon to move a like tooth, I would not use a jack-screw. I should use piano-wire, placing a band about the tooth so shaped that the piano-wire would not slip off, and secure the band to the tooth with zinc-phosphate. Two or even four teeth can be moved in the same manner at the same time. Always apply the rubber dam, and after the band is placed as near the gum as desired with zinc-phosphate, draw down on the rubber to smooth the phosphate next to the gum. When the phosphate is hard, remove the rubber and trim away the excess. At some future time I will describe my method of carrying the incisors forward bodily without changing their angle.

Dr. Dwinelle. I think it is time for old Archimedes to hide his diminished head. He must have been mistaken when he counted upon the force of the screw. A screw is a continuous circular wedge or lever, and it is irresistible. When I made the discovery, many years ago, that zinc in conjunction with steel prevented it from rusting, by reason of slow galvanic action, I said, "I will apply this to dentistry." The screw is the most powerful instrument known to mechanics. It is the universal testimony of everybody who has had any experience in such matters, excepting our worthy friend Dr. Jackson, that the jack-screw is also the easiest fixture that can be put into the mouth—that it causes less pain than any other. For a nine-year-old patient I would use a jack-screw from motives of humanity, if for no other, It is ridiculous to assume to limit the power of the jack-screw.

Dr. Atkinson. When I first saw Dr. Jackson I was pleased with him, and I am more pleased with him now than ever. I indorse the paper, the statements, and the deductions made on them as being exactly in the line of nature's laws; and I believe the heroic method of moving teeth is not a wise one. It is astonishing how much teeth may be moved by very light and constant traction; and he hit the keynote exactly when he said that continued pressure produces absorption. I am exceedingly pleased with what Dr. Jackson has presented, and I think he deserves the thanks of the society for it. He began with the coarse old methods, and has refined them until some of the small fixtures that he has shown are very neat and beautiful little appliances, just sufficient to hold the rubber or the springs that are to move the teeth. As to the half-round wire that he speaks of, I advised him to use it in certain cases because it gives a better grip on the tooth than round wire does; but he is right about the grip of the enamel; the round wire clasp has less contact with the enamel than the flat wire. I think we will get a great deal more benefit by just such evenings as this of interchange of opinion than by anyone's preachment about things they assume to know a great deal of. There are no two persons who require exactly the same treatment. I have moved teeth rapidly, and I have never but once moved a tooth that I was sorry for it, and that was a left superior lateral incisor, when I was in Cleveland. I moved it for the sake of getting room to fill and to carry it into line. I do not know to this day where my dereliction was, but I suspect there was a crooked end to the root of the tooth, and that by putting pressure on the unlucky side I choked the pulp until it died. That is the only case of bad result in moving teeth that I know of in my practice; and I do not remember of seeing any in the hands of other men. Where the remnant of the socket and the gum is in a soft and nodular condition after the teeth are in place, you need not fear bad results; it will come all right in time. When I found such a condition after operations in the treatment of what is now called Rigg's disease, I said, "You must not expect that the new alveolar process will be as nice as the original." But afterwards I found that when the teeth were properly held in place the reproduced alveolar process would be as sharp and the dental ligament as snug as if they were original productions. Patience in such cases is all that is needed; nature will take care of it.

Dr. Jackson. Many regulating plates are bungling, and having to be tied in, cannot be removed by the patient for cleansing purposes, which makes them very unsatisfactory. Every one of the plates that I have shown here to-night has been of a variety that can be removed by the patient, cleansed and put back without trouble.

A vote of thanks to Dr. Jackson for his paper and the exhibition of his models and appliances was passed.

Adjourned. S. E. DAVENPORT, D.D.S., M.D.S.,
Editor N. Y. Odontological Society.

AMERICAN DENTAL ASSOCIATION.

CHANGE OF PLACE OF MEETING.

The twenty-seventh annual meeting of the American Dental Association will be held at Niagara Falls, commencing Tuesday, August 2d, 1887. GEO. H. CUSHING, Rec. Secretary.

CHICAGO, June 25, 1887.

All railroads west of Chicago, and from Chicago leading to Niagara Falls, will carry members and delegate of the American Dental Association at one and one-third fares.

Tickets for the return journey will be sold by the ticket agent at the place of meeting at one-third the highest limited fare, only to those holding certificates signed by the ticket agent at the point where through ticket to place of meeting was purchased, and countersigned by the secretary or clerk of the convention, certifying that the holder has been in attendance upon the convention.

Tickets are good going three days before the meeting and returning three days after its termination. A. W. HARLAN,
Chairman Executive Committee.

THE annual meeting of the National Association of Dental Examiners will be held at Niagara Falls, on Monday, August 1st, 1887, at 3 P.M. FRED. A. LEVY, Secretary.

IMMEDIATE ROOT-FILLING.

By C. EDMUND KELLS, JR., D.D.S., New Orleans, La.

An article under the above caption, in the April number of the DENTAL COSMOS, attracted my attention solely from the standing of the author and of the journal in which it appeared. Had it been read in one of the little "quarterlies," and credited to an unfamiliar writer, it would need no notice.

The immediate filling of some thirty roots within a year—roots in which a portion of the pulp was alive—is deemed worthy of public attention. That each and every one displayed some vitality is insisted upon; therefore, roots containing dead pulps, roots in every stage of inflammation, are not therein considered, and are consequently not deemed capable of immediate filling. Now, what in fact is the "state of the art" at present in regard to treating pulpless teeth? I believe that dentists all over the country are filling, *at one sitting*, pulpless roots,—roots in all stages of inflammation, as well as those in which the pulps are wholly or partly alive; and not only filling them, but doing so successfully. At the time of learning this method I was fortunately favored with an epidemic of pulpless teeth, and of the first one hundred and thirty cases within two years a careful record was kept (as well as was possible under the varying conditions), and no failures ensued to my knowledge. This sufficed to convince me of the soundness of the doctrine.

To-day a root is treated as a simple cavity—cleaned, and filled at once, no matter what its condition. I know of but two exceptions to this rule,—one when so much swelling of the face exists as to render operating impossible; and again when there is so much bleeding through the foramen (in this case, of course, the pulp was alive, in part at least) that too much time is required to stop it. In each of these cases a second sitting is needed to complete the filling of the fang; but fortunately these conditions are not often met with.

If the abscess is caused by the dead pulp, and we remove that, from what source are we to look for further trouble? None.

If any débris is forced through the foramen, irritation will follow, but may usually be readily controlled. If all the pulp is not removed, failure may result from the imperfect operation, not from the imperfect method employed. I believe that any root may be cleaned as well in one sitting as in a dozen. That it is possible to fill all, absolutely perfectly, I do not believe, but a degree of perfection is attained by the operator that insures success. To those who use them, drills and barbed broaches may be necessary; but to my mind they are dangerous, and I am content to be successful without their use. The natural size and shape of a root-canal I do not care to improve (?) upon. If too fine to fill, no trouble will ensue. The dead pulp in a canal too small to admit of a Donaldson smooth bristle need not be feared. It is immaterial what filling material is used,—all that is needed is one that is adapted to the exigencies of the case. Carbolized orange-wood and Guillois's cement subserve my purpose. For the cleansing of the canals, carbolic acid, c. p., and *nothing else*, is used.

Before dismissing such a case, it is indispensable to see that in the natural occlusion no pressure is brought upon the tooth.—*Dental Cosmos.*

* * *

MR. SMALE, of England, relates the case of a boy aged eight, who had the right upper central incisor twisted so that the mesial surface presented toward the lip. The tooth was grasped firmly by a pair of straight-bladed forceps and twisted into a good position, care being used to press the tooth firmly into the socket during the operation. It was tied to the surrounding teeth with silk twist, to prevent its returning to the old position. A week afterwards it was quite firm, the tooth could be tapped, and the boy could distinguish between hot and cold applications. There was no discoloration, and the gum was healthy. Torsion, says Mr. Smale, may be used freely before the partient arrives at the age of twelve years, and should always be done at one operation. It is only applicable to incisors.—*Independent Practitioner.*

DR. JAMES W. WHITE, editor of *The Cosmos*, has been appointed by the Mayor of Philadelphia, President of the Board of Charities and Correction. That Mr. White will worthily fill the office, no one who knows him will doubt.

AN excellent pickle for gold work may be preapared from the following formula: Oxalic acid, ½ oz.; sulphuric acid, 1 oz.; water, 6 oz.

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, August, 1887. No. 11.

MEDICAL DEPARTMENT.

DYSPNŒA.

A Clinical Lecture Delivered in the Ed nburgh Royal Infirmary December 17th, 1886.

By THOS. R. FRASER, M.D., F.R.S., F.R.C.P.E.,
Professor of Materia Medica and Clinical Medicine in the University of Edinburgh.

GENTLEMEN,—In the study of disease in the wards of the infimary your attention is very frequently drawn to the occurrence of dyspnœa, or difficulty in breathing. You have seen that it presents itself in various forms and degrees, in various conditions of the patient, and in connexion with many diseases. We have together studied several of its forms and varieties. We have seen it associated with disease of the heart, with morbid changes in the larger air passages, with pain in the thorax, and with diseases of the lungs; and it has been our endeavor to distinguish in each case any peculiarities in the phenomena which accompany it. We have seen, for instance, in cardiac disease, that it is associated with evidence of valvular lesions, or of dilatation of the heart, or of disease of the large bloodvessels that it is frequently paroxysmal, the paroxysms being induced by physical exertion or mental excitement, although even in the interval between each exacerbation it does not altogether depart; and that pain in the region of the heart or extending into the shoulders and arms is often one of its superadded miseries. In disease of the larger air passages, such as œdema or spasm of the glottis, constriction of the trachea, or paralysis of the vocal cords, we have several times observed that the great difficulty in respiration seems to occur during inspiration, which is labored and prolonged, while the expiration is relatively brief and without effort. In thoracic pain of pleuritic or neuralgic origin, the attitude of the patient, and especially the modifications in posture and movement adopted by him, are almost sufficient to characterize the dyspnœa apart from the readily discoverable conditions by which the pain was induced. In asthma, the opportunities for investigating the phenomena have not been altogether favorable, as our cases have presented the peculiarity, which so frequently occurs in this disease, that the dyspnœa has made its appearance only during the night or early morning. Most of you, however, are familiar with the circumstances that in asthma the dyspnœa is characterized by loud wheezing sounds and great prolongation of expiration, that it is paroxysmal in its manifestation, leaving the patient free or nearly so from all symptoms of breathlessness in the intervals, and that no structural alterations have as yet been discovered to account for the intense distress which marks each paroxysm. On the other hand, examples of the dyspnœa of bronchitis have been abundantly presented to you for consideration. You have seen that it is associated sometimes with acute, sometimes with chronic inflammation of the bronchial tubes, that it very frequently occurs in patients suffering from emphysema, that it is often paroxysmal, and that it is accompanied with pain or uneasiness over the front of the chest, with a sputum that may be tenacious or frothy and watery, and with such auscultatory phenomena as rhonchi and sibilations, crepitations, and prolonged expration.

While the dyspnœa in each of these conditions would supply abundant material for full and elaborate discussion, my intention to-day is to consider with you in further detail some of the phenomena presented by it in bronchitis and asthma only. I make this selection because our attention has been given in a more special manner during the last few weeks to a consideration of the breathlessness of these two diseases. I group them together because the dyspnœa frequently presents in them many points of similarity, and when it does so I believe that a large element in its production is an element operating in both diseases.

It is in pure (or nervous) asthma that dyspnœa assumes the most intense degree possible in disease of the respiratory apparatus. When the paroxysm occurs at night, the patient may go to bed feeling quite well, but is awakened from sleep by a feeling of suffocation. He sits up in bed in various constrained positions, or he is impelled to leave his bed altogether and walk about, resting now and again to recover strength. He struggles violently for breath; inspiration and expiration succeed each other rapidly for a short time; then expiration becomes brief, the chest seems to become rigid in full expiration, violent respiratory efforts are made, with but little change in the volume of the thorax, and the extraordinary muscles of respiration are brought into play with very inadeqate results. After this state of distress has lasted for some time, it may be for hours, relief is obtained, and the patient returns to bed and usually soon falls asleep; but on many occasions this sleep may in a short time be again interrupted by a recurrence of the paroxysm. The great difficulty in asthma seens to be to expel air from the chest, and the expiratory muscles are strained to the utmost in the effort to accomplish this. If the condition of the patient during the period of dyspnœa be further examined, several other phenomena of significance are observed. The normal relationship between inspiration and expiration is found to be reversed, and in place of inspiration being longer than expiration, the latter seems sometimes to be two or three times as long as inspiration. The contrast with dyspnœa produced by constriction of the glottis or trachea, where inspiration is greatly lengthened in its duration, is therefore a very pronounced one. The diaphragm, further, is unduly low, the chest is expanded, and the percussion note is markedly resonant; while, on auscultating the chest, not only is confirmation obtained of the great prolongation of expiration, but every variety of dry râle is heard, snoring, creaking, and whistling sounds displacing each other in different parts of the chest.

Now, what is the cause of this intense dyspnœa? No anatomical lesions, as I have stated, have been found that are sufficient to account for it. It was explained by Willis, and subsequently by Cullen, Romberg, Salter, and others, as due to a spasmodic affection of the muscles and nerves of respiration, and especially of the muscles in the bronchi; and this explanation was generally coincided in for more than half a century. It has not, however, been allowed to remain in undue posssession of the field, for at various times other and opposing explanations have been advanced. For ings of the skin in nettle rash.

These views represent the more important of the contending explanations that have been advanced. It cannot be pretended that any single explanation has yet been established by the evidence that has been produced in its favor, although I think that the explanation which accounts for the essential phenomena of an asthmatic paroxysm by spasmodic contraction of the bronchial muscles is still the most generally accepted one. But while a spasmodic influence has thus been fully recognized in the production of the dyspnœa and of other of the essential phenomena of example, Leyden considered that the asthmatic dyspnœa is caused by irritation of the vagus terminations in the bronchi produced by minute sharp-pointed crystals; but this explanation, after all, involves the production of a spasmodic contraction of the bronchi by reflex irritation. Wintrich denied that spasmodic contraction of the bronchi is possible, and maintained that the only explanation consistent with the phenomena is to be found in tonic spasm of the diaphragm, or of the diaphragm aided by the other ordinary muscles of respiration. Traube, Weber, and Sir Andrew Clark have ascribed the paroxysm to sudden congestive swellings of the bronchial mucous membrane, through the agency of vaso-motor nerves, the changes produced being likened by Clark to the swell-asthma, the existence of a spasm element in bronchitis has been but partially acknowledged. Indeed, so far as my acquaintance with the literature of this disease is concerned, spasm of the bronchial muscles is by the greater number of writers ignored as a condition that is ever, much less that is frequently, present. Bronchitis, however, resembles asthma in so far, at least, that in a considerable number of cases dyspnœa is frequently an important symptom, and that rhonchi and sibilations are among the most significant of its phenomena. The production of these rales has generally been attributed to stenosis of the bronchial tubes caused by engorgement, or swellings, or puckerings of the lining membrane, or to deposits of adhesive mucus upon this membrane.

It cannot, gentlemen, be too frequently impressed upon your consideration that the ultimate objects of all our observations, studies, and investigations in pathology and medicine are the relief of suffering and the cure of disease. These objects will be the more certainly accomplished, the more accurate is our knowledge of the conditions that produce the symptoms of the diseases. I am not without hope that an illustration of this almost self-evident proposition may be found in some facts bearing upon the causation of the dyspnœa in asthma and in bronchitis, which I shall now proceed to describe. Let me first remind you that there are several well-recognized homologies in the structure and nerve connexions of the bronchi and of the smaller bloodvessels. They both contain non-striped muscle, and both are innervated by partly independent centres distributed in their walls, and by nerves proceeding to and from centres remote from themselves.

Although the effects of pharmacological agents upon the functions of the muscle and nerves of bloodvessels have been elaborately studied, their effects upon the functions of these structures in the bronchi have been but little investigated. Among the most striking of the results that have been obtained by pharmacology in the study of the influence of agents upon the bloodvessels is the demonstration that various nitrites cause a dilatation of the bloodvessels by an action restricted to the bloodvessels themselves. It was suggested to me by this fact that light might be thrown upon the production of dyspnœa in asthma and bronchitis by examining how far the dyspnœa and some of its associated phenomena could be modified by the action of nitrites. It seemed to be of importance to include in this observation not only the influence upon the dyspnœa (for any influence on it alone might be explained by an action upon nerve structures remote from the bronchi themselves), but also the influence upon the associated phenomena which have their seat of origin, without doubt or ambiguity, in the bronchi themselves. The associated phenomena, to which I attach the greatest importance, are the dry râles, audible in these diseases when the chest is auscultated, and conspicuously present along with the dyspnœa.

The first observation I made with these objects in view was in 1880, on a patient twenty-two years of age, of markedly nervous diathesis, who had suffered from asthma for several weeks. The chest was auscultated during an asthmatic paroxysm of moderate severity, and it was found that cooing, whistling, and creaking râles were abundantly present. She inhaled during fifty seconds a few minims of nitrite of amyl. Two minutes after the inhalation had been commenced the râles had entirely disappeared and her breathing had become quite easy. In another minute the râles had returned and the breathing had become more difficult. After an interval of six minutes, when both the râles and dyspnœa were present in their original abundance and severity, she again inhaled nitrite of amyl, this time for thirty seconds, and in forty-five seconds after commencing the inhalation the râles had entirely disappeared and the breathing was perfectly unembarrassed. In five minutes afterwards, the original state of breathlessness, with its accompanying auscultatory phenomena, had returned. After an interval of ten minutes, nitrite of amyl was a third time inhaled, with essentially the same results as on the previous two occasions.

This observation showed in a very striking manner that nitrite of amyl very rapidly caused every sensation of dyspnœa to disappear. The coincident effects of the highest interest were that so long as the dyspnœa was removed, and only so long, were the cooing, whistling, and creaking sonds silenced, and so long also were there present those well-known modifications in the pulse characteristics which indicate dilatation of bloodvessels. Since this observation was made I have accumulated much evidence of a similar kind. In a few other cases nitrite of ethyl as well as nitrite of amyl were given by inhalation, but in the greatest number of the observations the administration was effected by the introduction of the nitrite into the stomach, and thus a much more prolonged action was obtained. In this manner, not only has the influence of nitrite of amyl and of ethyl been examined, but also that of nitrite of sodium and of the nitrite-acting substance, nitroglycerine, Further, in several cases of severe asthmatic orthopnœa occurring during the night, remarkable alleviation, without coincident silencing of the râles previously abundant in the chest, were obtained in several observations made for me by Dr. Vaughan and Mr. Toft on patients in the wards.

In bronchitis accompanied with dyspnœa similar effects were also obtained. The dyspnœa was removed, and at the same time the previously existing dry râles disappeared. Let me illustrate this action of nitrites in two patients suffering from bronchitis, now placed before you. One of the patients has been in the wards for several weeks, and from previous experience I can confidently predict the changes that will occur. He has suffered at intervals during the last fifteen years from bronchitis, the lungs are emphysematous, and his chief complaints at present are breathlessness and cough with a rather adhesive and slightly frothy sputum of small quantity. The other patient was admitted into the hospital only yesterday, but I shall be much disappointed if the observation I shall immediately invite you to make on her should fail as an illutration. Her cough originated four months ago from a severe wetting. You observe that she has very obvious dyspnæa, and the sputum which I show you is large in amount, watery, and contains much froth. Both patients are suffering at the present moment from dyspnœa, and, as you have heard from the four members of the class who are examining the patients, two of whom are continuously auscultating the chest of each a patient, there are now associated with the dyspnœa an abundance of snoring, whistling, and cooing râles. I now ask Dr. Jeffcoat, the resident physician, to give to one patient four minims of nitrite of amyl in a little water, and to the other two minims of a 1 per cent. solution of nitro-glycerine, also mixed with a little water; and the gentlemen who are auscultating will at once inform us of any change in the sounds which they hear, while I have asked the patients to announce the first change which they experience in their sensations. It is only a very few minutes since the medicines have been given, and already you have heard, almost simultaneously, that silence prevails in the chests where before there was a continuous succession of sounds, and that both patients find that they no longer experience any dyspnœa.

The significance of the facts I have now brought before you in connexion with the influence of nitrites upon the dyspnœa of asthma and bronchitis, some of which you have yourselves assisted in observing, is almost self-apparent. They appear to throw light upon the production of the dyspnœa of asthma, and in doing so to confirm the conclusion otherwise arrived at by Biermer that the dyspnœa cannot find its chief explanation in spasm of the diaphragm. They appear also to show that this dyspnœa does not depend on suddenly produced and vanishing constrictions of the bronchial tubes, caused by swellings of a hyperæmic, herpetic, or urticaria-like character; for the means that have been successfully employed to control and terminate the dyspnœa are the very means which should, according to the theory which involves constrictions of this kind, be the most efficient for increasing and prolonging it. Relief of the dyspnœa and removal of the accompanying râles were simultaneously or nearly simultaneously produced by nitrites, whose action is to increase hyperæmia by dilating bloodvessels. As nitrites, however, lessen the contraction of nonstriped muscle, it appears to follow that the râles which accompany the dyspnœa of asthma are produced by spasmodic contractions of the bronchial muscles, that the dyspnœa is the mainly the result of spasmodic constrictions of the bronchial tubes, and that therefore the old doctrine which attributes the asthmatic paroxysm to spasm of the bronchi is in all probability the correct doctrine. In reference to their bearing upon the dyspnœa of bronchitis we have these facts to assist us: that whenever rhonchi and sibilations accompanying dyspnœa were removed by nitrites, the dyspnœa was also removed or lessened; but when the rhonchi or sibilations were unaffected the dyspnœa was not appreciably lessened. It could not be expected that in all cases of bronchitis the administration of nitrates would be followed by complete relief of the dyspnœa and complete removal of the auscultatory phenomena. In this disease dyspnœa is sometimes produced by mucus or other inflammatory products accumulated in the bronchial tubes, and rhonchi are sometimes heard which are caused by a viscous condition of these accumulated products, and even by accumulations of a similar kind in the throat. In such cases nitrates fail to give complete relief, and they fail to silence the abnormal sounds. That they should fail is a confirmation rather than a refutation of the opinion which I wish emphatically to state—that stenosis of the bronchi due to spasmodic contraction of the bronchial muscles is a frequent cause of the dyspnœa of ordinary bronchitis.

I have not obtained any facts that would justify the preference of any one of the nitrites because it possesses therapeutic advantages over the others in the treatment of asthma or bronchitis. There are, however, conveniences of administration which lead me to give a preference to nitrite of sodium and to nitro-glycerine. They are both extremely stable, and they can readily be given in solution, either by the stomach or by subcutaneous injection. These advantages are not possessed by nitrite of amyl and nitrite of ethyl, and even the latter substance in the alcoholic solution of the *spiritus ætheris nitrosi* of the Pharmacopœia is notoriously a very uncertain preparation. It is probable that the favor with which this preparation is, notwithstanding, regarded, is due not only to the action on the circulation which it shares with the other nitrites, but also to its previously unrecognized influence on dyspnœa, which is no doubt exerted when it is administered, as it so frequently is, in the treatment of bronchiol catarrh. When the volatile nitrites are given by inhalation the effects are only of brief duration, but when they are given by the stomach the effects are similar in their relatively prolonged duration to those of the non-volatile nitrites. Nitrite of amyl, nitrite of ethyl, nitrite of sodium, and nitro-glycerine have each proved successful in my observations in relieving the dyspnœa of asthma and brohchitis. I believe they do so, gentlemen, by removing bronchial spasm, and the remarkable power which they possess in doing this will probably lead to their being more largely used than they hitherto have been in the treatment of disease. Where their administration is successful in removing the auscultatory evidences of such spasm, it is difficult to imagine anything more convincing of the beneficial influence that can be exerted upon the conditions of disease by pharmacological agents. The observer has presented to him a patient in whose thorax a continuous succession of varying sounds is heard. Within a few minutes after a nitrite has been administered, the endless succession of noisy breath accompaniments gives place to an almost complete silence, in which only the subdued quiet of normal respiration is heard, and at the same time, what to us is of even greater interest and importance, the distress of dyspnœa, or, it may be, the intense suffering and anxiety of orthopnœa, is entirely removed.—*The Lancet.*

◆

TOXIC EFFECTS OF LEAD.—Mr. Wynter Blyth has had an opportunity of examining portions of the bodies of two out of five persons who have at different times died more or less suddenly from, as it is believed, the effects of lead poisoning. In one case he separated about a third of a grain of sulphate of lead from the liver and about a thirteenth of a grain from one kidney, besides finding lead qualitatively in the brain. In the other he was able to examine the brain with more minuteness, and estimated that here the cerebrum contained about a grain and a half and the cerebellum about a quarter of a grain of sulphate of lead. Mr. Blyth went on to remark, in the paper he read to the Chemical Society of London on these investigations: "There has hitherto been no reasonable hypothesis to explain the profound nervous effects of the assimilation of minute quantities of lead, but if it is allowed that lead forms definite compounds with essential portions of the nervous system, it may then be assumed that in effect it withdraws such portions from the body; in other words, the symptoms are produced not by poisoning in the ordinary sense of the term, but rather by destruction—a destruction it may be, of important nerve centres.—*The Lancet.*

THE ABUSES OF MILK DIET IN THERAPEUTICS.

By ROBERTS BARTHOLOW, M.D., LL.D.,
Professor of Materia Medica, Therapeutics and Hygiene in the Jefferson Medical College; Physician to the Philadelphia Hospital, etc.

The therapeutical employment of milk, not only has been popularized and the lay public made familiar with its various adaptations, but in the wake of the general appreciation has followed the usual exaggerations, and hence it is prescribed with little regard to the conditions properly requiring it. Under these circumstances it seems desirable to indicate the limitations of this therapeutical food, and to show wherein it may be hurtful rather than beneficial.

In certain disorders of the digestive functions, milk causes a sense of discomfort, decided uneasiness, oppression—sometimes even pain, and it prolongs the morbid condition. The cases of this kind may be grouped into two classes: those in which the casein is the offending material; those who cannot properly digest the cream or butter. We find examples of the first class more frequently amongst children, but they are by no means uncommon in adults. They are detected the more readily in early life, because the curds are rejected by vomiting, or appear undigested in the stools. Adults unable to digest casein, or who digest it slowly or painfully, have epigastric distress, heaviness and oppression for several hours after meals, stupor and disinclination for exertion coming on after an hour or two and continuing until the offending material has passed well down the intestines.

An excellent substitute for the milk when the casein disagrees is barley-water with cream, The barley-water should be carefully strained and have the density of good skimmed milk, and one-sixth or one-fourth cream added, so that the mixture has the consistency of rich milk.

Another class of subjects to whom milk is unadapted are the cases of duodenal, hepatic and pancreatic diseases, because of the deficiency in the secretions necessary to the process of emulsionizing fats, and preparing them for entrance into the lymph vessels. Fats decomposing form very irritating fat acids, and the change in the reaction of the intestinal juices is the cause of various secondary troubles in the biliary functions and elsewhere.

To fit milk for use under such circumstances, it must be skimmed, and about the time the stomach digestion is completed, aids to the intestinal digestion should be administered. Such aids are a soda alkali, and it may be, some pancreative solution to effect complete digestion of the fatty constituents.

The mere bulk of the milk is an objection to its use in certain diseases. In dilatation of the stomach, the space occupied by the necessary quantity perpetuates the disease. The reflex effects of distension of the stomach in cases of weak heart, and in angina pectoris, may not only cause distressing symptoms, but may even prove fatal. It cannot be too strongly stated that milk is a highly objectionable aliment in heart diseases, whenever the motor apparatus of the organ is diseased, and whenever its movements are readily influenced by morbid states of the stomach through the reflex channels.

In no malady, as I conceive, is milk more abused than in acute rheumatism. It is very often the chief—sometimes the only aliment employed during the whole course of this disease. Besides the objection inherent in its mere bulk, certain theoretical considerations of its nature should have considerable weight in deciding the question of nse. The very obvious objection that milk furnishes lactic acid as a product of its fermentation, should not be ignored. All the world knows the intimate relation between lactic acid and the rheumatic poison. By the introduction of lactic acid, a form of endocarditis not distinguishable from the rheumatic, is set up, and of those diabetics treated by lactic acid, a considerable proportion suffered from attacks of rheumatic fever (acute rheumatism). It is difficult, of course, to determine this point with certainty, but I have reason to believe that patients with rheumatic fever do not get well so quickly, and are much more apt to have relapses when they consume much milk during the course of the disease. Surely, sufficient reasons exist for undertaking a thorough investigation of the question. My own practice, in the cases in which I am consulted, is to advise against the use of milk as an aliment in acute rheumatism.

In typhoid fever, milk is the one food now given, irrespective of the character of the cases. Of late this almost universal practice has come to be challenged. It has been depended on, without investigating the state of the digestive functions, and quite unmindful of the effect it may have on heat production. It is often given in too great quantity at a time, or so frequently that the stomach has not disposed of one quota before another is thrust upon it. Unless the gastric juirce has preserved to a considerable extent its power of converting the albuminoids into peptones—which we have no right to expect—the casein resists its action; hence it follows that the materials of digestion should be administered soon after the milk is taken, and to prescribe it without reference to the ability of the stomach to dispose of it is to insure increased fever and delirium, and more frequent stools. Beside supplying the means for proper digestion of the milk, attention should be given to its administration at such intervals that every portion given may be disposed of before another is permitted to enter the stomach. It is a trite observation, which is not therefore less true, that it is more important to the nutrition if some food be well digested rather than a large amount be merely swallowed.

Notwithstanding, since Donkin's first reports, milk has entered largely into the dietary of diabetics, its utility has recently come to be seriously questioned. If conversion of milk sugar into grape sugar does not take place, there can be no doubt of the value of milk in this disease, since it possesses so great a number of alimentary constituents. If, as is now asserted, this conversion does take place, the free administration of milk in diabetes, must be regarded as an abuse.—*Jour. of Reconstructives.*

◆

SUBSTITUTE FOR A DOUBLE CATHETER. — D.. H. N. Allen, of Seoul, Corea, writes: "Such an instrument may be readily improvised for washing out the bladder (especially of a female) by making an eyelet on the opposite side of a No. 12 rubber catheter, and passing into the No. 12 one of say No. 4 size. The fluid can then be injected through the No. 4, coming out through the regular eyelet of No. 12, and returning through the newly made eyelet. As this idea occurred originally with myself, I presume it has already occurred to many other practitioners. But as it may not have suggested itself to every one to whom it may be useful, I mention it for what it is worth. It allows of the employment of a new, clean instrument for every case, as well as supplies the demand when the regularly made article is not at hand.—*N. Y. Med. Record.*

EDITORIAL.

A. B. THRASHER, A.M., M.D., Editor.

SUN-STROKE.

The recent heated term in Cincinnati has induced the usual number of sun-strokes.

At the beginning of the hot spell a prominent physician gave in the public press a lucid explanation of the phenomena of insolation, together with the rational treatment to be followed. The next day appeared another communication from another physician, advising almost a diametrically opposite course of treatment. The editor of a Cincinnati daily, in referring to this diversity of opinion, wondered why it was and which course the people should follow.

Some fifteen years ago Prof. H. C. Wood, of Philadelphia, made an exhaustive study of sun-stroke. Since then the profession has been pretty unanimous in the opinion that the symptoms are all caused by hyperpyrexia. Self-consciousness is lost when the brain is heated to 108°, and death ensues at a few degrees higher. A slightly higher temperature coagulates myosin, and in cases of muscular activity the myosin is coagulated at much lower temperature. Then, in hyperpyrexia, death might result from (*a*) failure of breathing by paralysis of respiratory centres, or (*b*) by failure of heart from coagulation of myosin in heart muscle. Parkes, in his work on Practical Hygiene, cites a number of sudden deaths in the Ninety-eighth regiment during a charge up a steep hill on a hot day. Some of the "men fell suddenly on their faces as if struck by lightning, and on his running up and turning them over many of them were already dead."

A high bodily temperature, especially in those engaged in severe physical exercise, then being the cause of sun-stroke, the remedy suggests itself.

By way of prophylaxis, the body should be kept in a high state of health. If the glands are in a healthy state a high degree of atmospheric heat will not cause a corresponding elevation of the heat of the body. By the intestinal tube, the urinary apparatus, and, more especially, by the excretory glands of the skin, heat is eliminated from the body and a normal temperature maintained. But if, from any cause, these great systems will not perform their work—whether it be from too liberal potations to Bacchus or undue worship at the shrine of Venus, or from any abuse or neglect of the goddess Hygea—then the heat of the body rapidly rises, and unless artificially checked the danger line is soon reached.

Ice-water in large quantities does not act as so good a diuretic and diaphoretic as does simply cool water. Ice-water, taken in small quantities and frequently repeated, acts on the stomach and system not as ice-water, but simply as water—hence should be used in this way in hot weather.

Severe physical labor, by its effect in increasing the bodily temperature and by its lowering the resisting power of muscle to heat, should be avoided when the thermometer is over 90°.

When called to see a case of sunstroke what should the physician do? First, see that it is a case of sun-stroke and not one of apoplexy or alcoholism ; the thermometer will generally determine the question. Then, if the patient is suffering from a high temperature, your first duty is to lower the temperature. The most rapid method of accomplishing this is the cold bath, or, if that is impracticable, affusion. Antipyrin may also be given (hypodermically) for the purpose of keeping the temperature down. Having reduced the temperature, *then* is the time to regulate the machinery which has become blocked and failed to carry off the superabundant heat. Pilocarpine and hot water will probably flush out the perspiratory glands, but before they can accomplish that work the patient may die from hyperpyrexia. Hence, use them after the temperature has been lowered. Use your thermometer frequently in cases of sunstroke and be governed by the conditions present in the treatment of the case.

ENTERPRISE.—Wm. Wood & Co. will have a stenograpic report of the proceedings of the International Medical Congress for the New York *Medical Record.* This report will be forwarded to any medical journal in the world, printed in any language, on application to the *Record.*

HANDSOME CATALOGUE.—We are in receipt of a very handsome catalogue of Haussmann, McComb & Dunn, 122 E. Randolph St., Chicago.

The catalogue is illustrated and contains a description and price list of every instrument or apparatus in use by the surgeon or veterinarian. The catalogue will be found useful for reference by all practitioners of medicine and surgery.

AMERICAN RHINOLOGICAL ASSOCIATION. –The next meeting of the American Rhinological Association meets in Washington, September 1, 2 and 3. Papers are promised from:

Dr. T. H. Stucky, Louisville, Ky.
Dr. N. R. Gordon, Springfield, Ill.
Dr. A. G. Hobbs, Atlanta, Ga.
Dr. F. M. Rumbold, St. Louis, Mo.
Dr. A. B. Thrasher, Cincinnati, O.
Dr. Thos. F. Rumbold, St. Louis, Mo.
Dr. P. W. Logan, Knoxville, Tenn.
Dr. John North, Keokuk, Iowa.
Dr. A. DeVilbiss, Toledo, O.
Dr. C. H. Von Klein, Dayton, O.
Dr. H. Jerard, East Lynne, Mo.
Dr. J. A. Stucky, Lexington, Ky.
Dr. J. G. Carpenter, Stanford, Ky.
Dr. S. R. Knode, Ft. Wayne, Ind.
Dr. Wm. Castor, Corsicana, Texas.
Dr. Jno. D. Simpson, Bloomington, Ind.
Dr. E. L. Siver, Ft. Wayne, Ind.
Dr. A. J. Vance, ——

This meeting, it will be seen, occurs the week before the meeting of the International Medical Congress, so that one trip will suffice for both meetings.

◆

CUCAINE IN WHOOPING-COUGH. — Repeated painting of the throat with a 5 per cent. solution of cucaine is stated by Dr. Lahric to have caused an immediate lessening in the number of attacks, children having fifteen or twenty attacks in the twenty-four hours only having five to ten attacks after the application. As the topical effect of the drug is of short duration, it is necsssary to repeat it fairly often, but no tolerance is established, as with other drugs. Improvement took place in the general health, probably due to the diminution in the cough.—*London Med. Record.*

ABSTRACTS.

INFLUENCE OF TEA, COFFEE AND COCOA ON DIGESTION.

An abstract from an article of Dr. Jas. W. Frazer appears in the *Lancet* May 7th, 1887, from which we take the following conclusions:

1. That it is better not to eat most albumenoid food stuffs at the same time as infused beverages are taken, for it has been shown that their digestion will in most cases be retarded, though there are possibly exceptions. Absorption may be rendered more rapid, but there is a loss of nutritive substance. On the other hand, the digestion of starchy food appears to be assisted by tea and coffee; and gluten, the albuminoid of flour, has been seen to be the principle least retarded in digestion by tea, and it only comes third with cocoa, while coffee has apparently a much greater retarding action on it. From this it appears that bread is the natural accompaniment of tea and cocoa when used as the beverages at a meal. Perhaps the action of coffee is the reason why, in this country, it is usually drunk alone or at breakfast, a meal which consists much of meat, and of meats (eggs and salt meats) which are not much retarded in digestion by coffee. 2. That eggs are the best form of animal food to be taken along with infused beverages, and that apparently they are best lightly boiled if tea, hard boiled if coffee or cocoa, is the beverage. 3. That the casein of the milk and cream taken with the beverages is probably absorbed in a large degree from the stomach. 4. That the butter used with bread undergoes digestion more slowly in presence of tea, but more quickly in presence of coffee or cocoa; that is, if the fats of butter are influenced in a similar way to oleine. 5. That the use of coffee or cocoa as excipients for cod-liver oil, etc. appears not only to depend on their pronounced tastes, but also on their action in assisting the digestion of fats.

THEISM—THE NEW NERVOUS DISEASE.—Attention has recently been drawn to a new nervous disorder said to be especially prevalent in England and America; it is called "Theism," or tea-drinker's disease. It is said to exist in three stages—the acute, subacute and chronic. At first the symptoms are congestion of the cephalic vessels, cerebral excitement, and animation of the face. These physiological effects, being constantly provoked, give rise, after a while, to reaction marked by mental and bodily depression. The tea-drinker becomes impressionable and nervous, pâle, subject to cardiac troubles, and seeks relief from these symptoms in a further indulgence in the favorite beverage, which for a time restores to a sense of well-being. These symptoms characterize the first two stages. In chronic cases theism is charcterized by a grave alteration of the functions of the heart, and of the vasomotors, and by a disturbance of nutrition. The patient becomes subject to hallucinatlons, "nightmares," and nervous trembling. With those who take plenty of exercise, an habitual consumption often may be indulged in with impunity, but with women and young people who follow sedentary occupations this is not the case. The best treatment for theism is said to be indulgence in free exercise, such as walking and open air life.—*Journal of the Amer. Med. Association.*

CHRONIC CYSTITIS.—By the late Prof. Willard Parker, of New York (*Boston Med. and Surg. Jour.*, April 7, 1817).

Dr. James R. Chadwick selected the following letter with two others, written by Dr. Parker to Dr. Edward Jarvis, of Dorchester, and donated by Dr. Jarvis with a large number to the Boston Med. and Lib. Association.

NEW YORK, March 13, 1881.

I was very glad to hear from you through your letter, and to know you are comfortable. I had not heard of the accident you met with; you say you were thrown from the top of a carriage; pray, what were you doing in that position? The good book, you know, says, persons like us are afraid of that which is high and fears should be in the way. I am sorry Hosmer (Rev. Dr. Hosmer of Watertown, a classmate) is among the suffering ones. He paralized the bladder by retaining the urine too long a time. When old, we must obey the call of nature. His trouble is cystitis chronic, kidneys are sound, the reaction is acid, although feebly. He should neglect no means of recovery. The triple phosphates show the urine meets with pus in the bladder; the urine is decomposed by it, and the irritation is kept up. The specific gravity is right, or nearly so.

Now in order that our dear old classmate recover, he must eat *little strong meat*, and make less urea; the nearer his urine approaches *pure spring water* the better. Breadstuffs, milk, mild fruits—you tell him what to do. The bladder should be *washed out at bedtime* with *warm* soft water and have the organ completely emptied; washing out in this way he will go without much disturbance during the night and gain strength. If he do not recover, some slight medication of the wash may aid: an infusion of *buchu*, and in the twenty-four hours or every twelve hours a couple of the capsules of the capaiba may be employed. I have found the greatest relief from washing out the pus and triple phosphates.

When you write to Hosmer, please assure him of my profound sympathy; we are all admonished that the *Conscious Ego*, the individual which says my hand, eye, or body, is making preparations to leave this tenement as the landlord is slow to make repairs. WILLARD PARKER.

MAMMARY ABSCESS.—Mrs. J. H., white, æt. 22, delivered seven months ago of a healthy child, which she nourished at the breast. After exposure, she experienced a succession of rigors, accompanied by severe aching in head, back and limbs, lancinating pains through the right mamma, and followed by fever. I saw her eighteen hours later. Pulse was 120; temperature 103° F.; tongue furred, marked general malaise. The outer and lower segments of right mamma were swelled, red, tense and glistening, and exquisitely sensitive to the touch. I ordered a saline laxative at once and ten drops fluid extract phytolacca decandra to be taken every two hours until relieved of fever and pain. To the breast I applied a square piece of rubber tissue, such as is used by dentists, sufficiently large to cover the whole organ, by tying a tape to each corner. Two of these tapes were passed around the waist and tied at the back. The two upper tapes were passed, one over the left shoulder, the other under the left axilla, and tied so as to maintain equable pressure over the affected mamma. A small opening was made for the nipple, and milk was occasionally drawn from the breast during the following night, at first by a breast glass, and later by the child. In twelve hours all symptoms of abscess had disappeared.

No form of support can be devised which is so comfortable to the patient by thoroughly relieving the dragging weight of the inflamed breast, while its equable pressure promotes absorption and prevents extension of inflammation or burrowing of pus. The tapes must be *tied* to the corners of the tissue. The gathering at its corners assists in adapting it to the contour of the breast, and besides the tissue is easily torn if punctured by a pin or needle. Care must be taken to remove the rubber as soon as the signs of inflammation disappear, or the secretion of milk will be permanently arrested. Where it is desirable to maintain the flow, I have found benefit from the use of the phytolacca, whether administered internally or applied locally.—*N. O. Med. and Surg. Jour.*

"ACROMEGALLY."—Another example of the curious and rare condition of acromegally of which an account was first given by Dr. Marie (THE LANCET, 1886, vol. i, p. 1060) last year, has been recorded by Dr. Minkowski (*Berl. Klin. Woch.*, 1887, No. 21). The case occurred in the medical clinic at Konigsberg, the subject being a musician, thirty-eight years old, who for some years past had experienced a gradually increasing size of the hands and feet, so that he could no longer play the violin. The nose and ears also became thickened, and the whole form of the face altered. He had suffered much from headache, and his vision had become gradually impaired; he had also become somewhat deaf. He was a man of medium height. The hands were strikingly enlarged in width and thickness, the fingers especially, the thickening involving both bones and soft parts. There was no œdema. The forearm was disproportionately enlarged. A parallel increase in the size of the peripheral parts was seen in the lower limbs, where the leg and foot were greatly enlarged, as well as the individual toes, the great toe being "gigantic." The patella was notably enlarged. As to the face, the nose, lips, and chin were manifestly hypertrophied, the septum as well as the tip of the nose being much thickened. The lower jaw was thickened and projecting, the zygoma and the orbital margins prominent. The head had a long oval shape. The ears were large, and their cartilages thick. The eyes were prominent, the tongue was large, and the buccal mucous membrane hypertrohpied. The laryngeal cartilages were voluminous, the thyroid body apparently atrophied. The muscles were ill-developed. Intellect was normal, but hearing impaired, speech slow, and visual field contracted. Marie's case also had symptoms of polyuria and polydipsia, but otherwise resembled the present one. Dr. Minkowski refers to the opinion of Klebs, who had recorded one of the cases collected by Marie, that the condition was due to a morbid proclivity to excessive vascular development, affecting chiefly the peripheral parts. It is noted that in the cases as yet examined after death the pituitary body has been found much enlarged; in one case (Henot's) it was the size of a hen's egg; in another (Brigidi's) it had caused enlargement of the sella tursica and compression of the optic nerves. The thyroid has been found in some cases atrophied, and in others greatly hypertrophied. One case has been recorded as myxœdema, but the resemblance between the two conditions is only superficial, the osseus changes and the absence of cutaneous lesion in acromegally, together with the wholly different physiognomy, sufficiently marking the difference. In Virchow's leontiassis ossea there is no such disproportionate enlargement of the extremities, and in Paget's osteitis deformans the long bones and cranial bones are chiefly affected, whereas in acromegally the facial and not the cranial bones are involved, and the distribution of the changes in the limbs is invariably symmetrical.—*London Lancet.*

THE TREATMENT OF LUPUS BY INJECTIONS OF CORROSIVE SUBLIMATE.—Dr. Iginio Tansini, of Lodi (*Gazzeta degli Ospedali*, June 12th), narrates the treatment of a case of lupus of the nose and face by means of repeated injections of corrosive sublimate. He began with a weak solution: corrosive sublimate 50 centigrammes, distilled water 100 grammes. This produced no reaction of any kind. A stronger solution—corrosive sublimate 1 gramme, distilled water 100 grammes—was then used. This produced some tumefaction and œdema in the neighborhood of the punctures, and slight suppuration in some of them. Some fourteen or fifteen injections of a few drops were practiced. Improvement soon became marked, and eventually all traces of the disease disappeared, the only marks left being those of the punctures in which suppuration had taken place. Dr. Tansini was led to try these injections by the following considerations: 1. That lupus is a form of tubercle. 2. That the bacilli are few and have no tendency to diffuse themselves. 3. That corrosive sublimate has proved certainly destructive to bacilli. He claims advantages for this method on account of lessened pain and disturbance and superior cosmetic results.—*The Lancet.*

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, August, 1887. No. 11.

DENTAL DEPARTMENT.

"A COOL WAVE COMING."

Mr. Editor:

I want to tell my friends of a valuable little instrument which I have been using for some time, and out of which I have had much solid comfort. I bought one of the little fans called the Electric Fan, believing, at the time, that it would play the part, for a short time, of a "pleasing novelty" in my office. You know we are always investing in new toys for our patients and ourselves! Well, I took the little thing home and started the fan on my operating table, and it did the work so effectually and quietly that I could not operate on a hot day without it, and my patients all acknowledged that it changed summer days into early spring days for them. Then, when the nights got so hot that a fellow felt more like getting into a bath-tub than into a bed, and when the mosquitoes began their concerts preparatory to getting in their more important work of dining off of perspiring humanity, I carried the little fan to my bed-room, and, placing it on a table by the side of the bed, started the wheel and away fled hot weather, mosquitoes and all. This is my third summer's experience with the electric fan, and I don't dread a "hot wave" as I used to. This was the extent of my use of the fan until lately—and I was satisfied with it—but I have seen its continued use in a sick-room where the thermometer registered 90° and the patient could get no rest and no sleep from the excessive heat, and the attendants were all tired out exercising the old-fashioned palm-leaf fans. Electricity was called in, and a most excellent servant she proved herself to be when directed to keep the fan going. Noiselessly, hour after hour, in the stillness of the night and in the heat of the day, the little fan sent an agreeable, perfumed air across the heated brow of the patient—and doctor and nurses, as well as the patient, expressed the utmost satisfaction with its efficient work. I feel so grateful for the instrument that I don't want to keep it to myself, but want all my friends to know how to keep cool and happy at the minimum of expense and trouble.

Yours, etc.,
C. M. W.

PAINLESS DEVITALIZATION OF PULPS.

(NEW YORK STATE DENTAL SOCIETY.)

[*Independent Practitioner's* Report.]

Dr. E. P. Brown: I have been in the habit of making my own arsenical paste for years. I found that with the use of morphia no uniform results were obtained; there would be cases of extreme pain after application. Then I used it in combination with cocaine; they mix very well, and I have not had the severe after-pains that I had with arsenic and morphia alone.

Dr. Wells: I am glad to hear this statement, because it shows the therapeutical effects of the agents. It seems to me Dr. Brown's experience shows clearly that cocaine, which is not as good as morphine in some instances, is better in others. I doubt that the arsenic neutralizes the effect of morphia.

Dr. Brockway: When I hear these objections made to morphine and cocaine, I think the trouble must be in the agents. I have for many years practiced the taking out of pulps after a simple application of arsenic and creosote, and the operation has been painless. I believe the nerve paste sold in the shops is simply arsenic mixed with creosote.

Dr. Dwinelle: I rise to endorse what has been said by Dr. Brockway. I have been in the habit of using a paste of arsenic, creosote and morphine, for the last forty years; I am a little bashful about saying how many more than forty. I have never failed to destroy the pulps without pain; I might almost say I never had a painful result. The trouble may be in the preparation used, but it has been my good fortune during that period to succeed in devitalizing nerves painlessly by that application. Arsenic, as we all know, is a poisonous caustic, and the other two ingredients modify the effect. Morphine is a sedative, and it qualifies the caustic properties of the arsenic. Creosote is also a sedative, and these in combination effect a result which is perfectly satisfactory.

Dr. Campbell: I would like to inquire what is the preparation of morphine that you use?

Dr. Dwinelle: The sulphate. I presume the acetate would be as effective.

Dr. Rhein: In the use of cocaine during pulp devitalization, a clear opening should be made to the pulp, and the finest needle of a hypodermic syringe inserted, and the cocaine forced through it. I have been successful in obtunding a pulp in a few minutes. I have never had any failure in using cocaine when I have been able to introduce the point of a hypodermic syringe. I have for that purpose some points much finer than are usually made, with suitable curves to reach the places desired.

Dr. Tripp: Dr. Brown says that many preparations of cocaine are worthless; but there is a preparation which renders the excavation of sensitive teeth absolutely painless. It is the alkaloid dissolved in ether.

◆

DR. HERBST, instead of using a clamp for holding the rubber dam in position, cuts the point from a common pin, flattens it a little with a hammer, curves it to make it partially conform to the shape of the tooth, and inserts it next the tooth to be filled. The rubber dam is then hitched over it, and thus held until the ligatures can be adjusted. He thus reduces the discomfort to the minimum point.

To remove rust-stains from nickel-plated ware, the article is thoroughly greased, and after several days rubbed off with a cloth moistened with ammonia. If any spots are still visible they are touched with dilute hydrochloric acid and immediately rubbed off. The ware is then washed and polished with polishing powder.—*Pac. Rec. Med. Science.*

MEDICAL CASES IN COURTS.

By HENRY A. RILEY, ESQ., New York.

MEDICAL CONTRACTS.

There was a recent case in the New Jersey Court of Chancery, on the interesting question whether a physician could make an agreement such as to prevent him from ever practicing medicine in a certain locality. It appeared that a physician, intending to be absent from the city of Newark a considerable time, employed another to attend to his practice, but fearing his patients might be lost to him when he resumed his practice, he secured the signature of the attending physician to this agreement: "In consideration of this contract made with him by the said * * * the said * * * hereby covenants and agrees not to engage in the practice of medicine or surgery in the city of Newark at any time hereafter." The employed physician did, after the termination of his engagement, begin practice for himself in Newark, and suit was brought to prevent him from doing so. The answer was that the agreement was an unreasonable one, and was in restraint of trade and void of law.

The court held that the claim was correct, and an injunction should not issue to prevent the physician from practicing for himself.

The main ground for the decision is that the agreement covered too long a period of time; it might be many years after the death of the physician who was supposed to be benefitted. On this point the reasoning of the court will be interesting. The judge said: "The fault imputed to the covenant is that the restriction which it imposes is to endure for an unreasonable time—for a much longer period than will be necessary for the protection of the complainant. It interdicts the defendant, it will be observed, from practicing medicine or surgery in the city of Newark at any time hereafter. The restraint covers the whole period of defendant's life, and if an injunction is awarded enforcing the covenant according to its terms, the defendant can never at any time thereafter practice his profession in the city of Newark, though the complainant may the next year or even the next month after the injunction issues lose his life or his reason, or remove to another field of practice. Under such circumstances the injunction would give no protection to the complainant—he would need none; and the only purpose the injunction could serve would be to causelessly oppress the defendant.—*Dental Register.*

AMERICAN MEDICAL ASSOCIATION—RESOLUTION.

At the recent session of the American Medical Association the following resolution, introduced by Dr. N. S. Davis, was adopted by a unanimous vote:

Resolved, That the regular graduates of such dental and oral schools and colleges as require of their students a standard of preliminary or general education and a term of professional study equal to the best class of the medical colleges of this country, and embrace in their curriculum all the fundamental branahes of medicine, differing chiefly by substituting practical and clinical instruction in dental and oral medicine and surgery in place of practical and clinical instruction in general medicine and surgery, be recognized as members of the regular profession of medicine, and eligible to membership in this association on the same conditions and subject to the same regulations as other members."

Dr. Davis, in introducing the resolution, said he wished to explain its object: There are two objects to be had in view. First, to relieve a degree of embarrassment that exists between the regular profession as we consider it and the profession of dentistry. The department of dental and oral surgery is a part of the profession of medicine as much as the department of ophthalmology, or otology, or any other 'ology. Our mouths and teeths are parts of our system as much as any other part, and are used more than any other part. The embarrassment is this, that in the early history of dentistry it was but little if anything more than a mere mechanical pursuit. Steadily it has advanced, and in years gone by—quite a number of years ago—our lamented S. D. Gross made a proposition that an Oral and Dental Section be provided as a section in this association. It was seconded by Dr. Sayre and myself, and it was organized. The International Medical Congress of 1881 provided a section for Dental and Oral Surgery. The Congress to be held in Washington has done the same thing, and it will be one of the most thorough and best organized sections in the Congress. There is an embarrassment in this respect. It is to know just who and by what line of demarkation those engaged in that department shall be recognized as members of the regular profession. Now it is proposed to make a line, and draw it where this resolution says, that all those who are qualified by general education and a term of study equal to the best medical colleges, a curriculum embracing the entire fundamental principles of medicine, with the provision that, instead of special instruction in clinical surgery, instruction may be had in dental and oral surgery, such shall be recognized as members of the profession of medicine. It will take away a sort of embarrassment. There is a more far-reachsng and more valuable underlying object in this resolution, and that is that to be recognized as a member of the profession, if this resolution is adopted by this body, they must have the education received in schools that call for these requirements. It makes a strong lever to lift up the course of study in the dental schools. Such are my reasons for bringing up the resolution. I will say nothing more on the subject.

NINTH INTERNATIONAL MEDICAL CONGRESS.

NEW YORK, July 18, 1887.

EDITOR CINCINNATI MEDICAL AND DENTAL JOURNAL:

Will you please give notice that, as I am unable to continue the work of the Secretaryship of the Dental and Oral Section oj the International Medical Congress, Dr. A. M. Dudley, of Salem, Mass., has kindly consented to act.

All communications should henceforward be addressed to him.

Respectfully yours,
E. A. BOGUE.

TO DESTROY PULPS.—Dr. C. J. Tibbets says the following is better than the ordinary paste: 12 grs. caustic potash; 10 grs. very finely powdered arsenic, with water enough to make into a paste, now add 10 grs. crystal of cocaine.—*Items of Interest.*

W. TAFT, M.D., of Cincinnati, O., will fill the chair of operative dentistry in the Northwestern College of Dental Surgery, next winter.

EDITORIAL.

FRANK W. SAGE, D. D. S., - - Editor.

THE ABUSE OF DENTAL CHARITY.

Under the above caption the *Dental Review* publishes a very outspoken editorial, taking to task the dental colleges for abusing their opportunities by encouraging patronage from the wealthy or well-to-do classes. An outline of the writer's statements and criticisms includes the following ideas: The dental colleges advertise the rendering of services free, or at a merely nominal cost, placing no restrictions upon any who may choose to avail themselves of the privileges; the colleges in the large cities are, without exception, run as money-making institutions; their advertisements that fillings will be made at cost of material are false, their object being to entrap the unwary. From 300 to 400 per cent. over and above the cost of material is ordinarily charged, and very often a handsome fee is exacted and paid. Handsomely-dressed ladies in sealskin sacques are among the frequenters of the operating rooms, etc., etc.

From these considerations (and other not quoted above), the writer concludes that the evil referred to urgently requires attention on the part of the various dental college faculties. He says: "Private practice in Philadelphia has already been made to suffer seriously at the hands of the dental colleges, and the same evil threatens disaster to individual practitioners in other cities where colleges are located." The remedy suggested is to furnish "charity certificates" to public officials, physicians, dentists, clergymen, business men, and others who are willing and able to vouch for the patient's inability to pay a reasonable fee.

This is the first time we remember to have seen in print so unreserved an expression of opinion on this matter. The subject has been privately discussed among city dentists, to our knowledge. The statement that private practice has suffered seriously at the hands of any dental college would seem to require confirmation. Personally, we have never heard any particular dentist complain that his patrons have abandoned him in favor of the dental college. The fact that well-dressed persons have been seen among the patients at the dental college does not argue that some dentist has been robbed of a patron. By no means. As in many other matters, the question as regards dental services is, with certain penurious people, whether they shall get such services for a trifle or go without them. A good many dentists are so peculiarly constituted that they conceive a strong dislike for people who haggle about fees, so that their chief desire is to be well rid of them as quickly as possible. To cut the matter short, they perhaps recommend the dental college. No very extended inquiry would be needed to show that reputable practitioners occasionally send a poor but respectable-appearing applicant to the dental college, rather than leave him to drift into the hands of the cheap charlatan. The profession might perhaps do much to assist beginners in practice by sending poor but worthy applicants to them. But, as a matter of fact, most of the beginners want to be pretty well paid, too. Moreover, it should be remembered that the strictly pauper class can hardly be attracted in sufficient numbers to afford constant employment for a large class of dental students. They do not appreciate operative dentistry sufficiently to submit to the pain and tedium of operations, even when offered gratuitously. What is equally to the point, students are apt to be somewhat fastidious. A comely waiter-girl or a coy young chambermaid is regarded with more favor than a pock-marked pauper. The students select "material" to suit their individual tastes from among acquaintances picked up during their winter's stay in boarding-houses. We used to do it ourselves.

If, then, we take the classes a grade or two above the paupers, we must incur the risk of respectable clothing, and perhaps submit to the occasional intrusion of a sealskin sacque. We have had occasion to notice that the sealskin sacques are sometimes cheap imitations worn by "ladies," as the appellation is used, but ladies whose charms of person and character are more gracefully exhibited in the kitchen than in the parlor.

Take it all in all, we doubt whether the dental colleges can be shown to be working detriment to the interests of any reputable practitioner. They may injure the quacks. The private practitioner is protected, in the nature of things, by several considerations. Pride deters many, even of the deserving poor, from recourse to the college infirmary. Even when the suggestion is made by the dentist, it is quite as often as otherwise regarded with disfavor. Many are unwilling to submit to the unavoidable publicity, others are well aware that the dental student is not the best conservator of time, and others again reflect that it is enough to endure their own sufferings at the hands of an operator, without being made liable to behold and participate in the sufferings of a score or two of fellow-unfortunates. These considerations are the profession's strong arm of defense against abuses in the dental colleges.

Again, in one view of the matter, the interests of the profession are constantly menaced by the work the dental colleges are doing in educating so many young men to become competitors with the present established dentists. A dozen or so new men swell the ranks of the city dentists with the close of every winter's term. It would be interesting to know what effect is wrought locally in such cities as Philadelphia, Chicago, St. Louis, and Cincinnati, by their entrance into practice. In the latter city we find by reference to the directory, about ninety dentists in active practice. Of this number, thirty-six are *recent* graduates of the Ohio Dental College. We include in this list only those who have offices of their own, not those who are attached to old establishments. Thirty-six new offices! Eleven years ago the then established dental offices in Cincinnati were only about forty in number. Possibly, something of this kind has been going on in Philadelphia.

Before concluding that the dental colleges of Philadelphia have done so much mischief to dental practice, it might be well to poison a score or two of these young, pestiferous interlopers, in order to determine exactly whence the evil proceeds. But if it can be shown that the dental colleges are exceeding their privileges, that they are aiming to secretly divert wealthy patronage to their doors, we stand ready to join in the hue and cry against the abuse. It appears, upon consideration, that no great amount of shrewdness would be required of unscrupulous managers to enable them to conduct the dental college as a vast monopoly. Let two or three shrewd, discreet men get control of the majority of stock shares and the rest is easily done. It would be no very difficult matter to convert the large, public operating room into a dozen or a score of private offices, thereby removing one of the great bugbears which frighten away timid, refined people. The students furnish all the labor, not only demanding no salaries, but really paying from $50 to $100 per term for the privilege of practicing and being instructed. Many of them are fine operators, and under the surveillance of the professors, the college would quickly gain a reputation for excellence and thoroughness of operations, such as might well alarm the private practitioner. Many of the colleges already enjoy such a reputation, well merited, too. It is a matter of no concern to the student that his labor brings him no pecuniary reward. Be that as it may, he cannot afford to quarrel with the authorities of the institution. Unquestionably, by a little tact and management, the dental colleges could thus be made to return large revenue to the managers. However, come to think of it, we are not aware that students are required by any present existing regulations to operate every day. We have it, however, on authority of two officers of a well-known dental college, that their operating rooms have been crowded during the entire collegiate year, keeping a large class constantly busy. The uniform excellence of the work submitted for inspection gave evidence of plenty of practice on the part of the students. Still, some students are fine operators at the time of entering college.

Finally, we do not know that the colleges are sacredly pledged to the profession to confine their ministration to the very indigent or pauper classes. Inasmuch, however, as they look to the profession for countenance and support, it seems that deviation from what is presumed to be a proper course, *i.e.*, avoiding whatever may injure private practice, may be regarded as justly censurable. Of course, no local practitioner could be expected to cherish and encourage an institution which, under guise of elevating the profession by properly qualifying entering members, stealthily invades the field which should be left to fair competition among outsiders.

ARE THERE TOO MANY DENTISTS?

This question is supposed to have been propounded originally by a dentist. Whoever he was, it is probable that his own answer to the question could be found by transposing the first two words of the query. Figures do not always express truth, but they are of some value. Divide the population of the United States in 1880 (50,000,000) by the whole number of dentists (15,000), and we have 3,333 as the proportion of patients to each dentist. Deduct from this number the paupers, the insane, the infants, and the large majority who cannot or will not patronize dentists, and the average would probably be reduced at least one-half. If we consider further, the large proportion of visitants to dental offices who occupy time and attention without affording the dentist opportunity for a fee, another reduction from the average must be made. So much for the discouraging features of this question. Other statististics might be furnished of a more encouraging character. It seems that a multitude of dentists create a demand, instead of simply meeting it. This is more particularly the case than in the practice of medicine. Communities manage to live without dentists, which ought to support half a dozen. Facts may be supplied to prove that quality and not numbers in a community most affects the dentist's prosperity. In the East it is said that, despite close competition in prices, dentists, as a class, are prosperous. This holds good in towns and villages. From all that might be gathered, it would appear that there are not too many dentists, but there are too many who do not appreciate dental services. The further west we go the less evidence of prosperity we see among dentists, excepting in the money centres. There are many exceptions, but we are speaking now of the general average. Dentistry not infrequently goes hand in hand with some light trade, or merchandising, in states this side of the Mississippi, too. In view of these facts it is not strange that dentists everywhere look with longing eyes toward the cities. They expect there to find a class of appreciative patrons. Encouraged by promises of aid and influence from friends among the physicians, they crowd in and take their chances. After a time, perhaps, they become aware that even in cities a small proportion, comparatively, of all the population seek the dentist's services. And that small proportion is already attached to the established dentists. The trans-Mississippi region is destined to furnish a fine field for the coming generations of dentists. The enormous influx of emigrants from abroad is, thus far, only the vanguard of the army which will cover the western plains during the next decade or two. From 1870 to 1880 Europe laid nearly 40,000 miles of railway, only 2,000 miles less than the United States constructed. This means increased facilities for poor emigrants to reach the seaboard. Steerage rates from Liverpool have been reduced to $8.00. A few years ago it was $35.00. It is estimated that with the opening of the 20th century we will have a foreign population of 43,000,000. Nine-tenths of these emigrants go west. They will cover the western plains, and hundreds of growing towns will assume the proportions of cities. The next twenty years, it is predicted, will constitute one of the most remarkable epochs in the world's history, as afforded by the spectacle of the unprecedented development of America's great West. These foreign elements will not in themselves, perhaps, directly afford encouragement to the coming dentists. But they will develop the country, and that will attract native emigration more than ever, to develop the cities and establish trade and manufactures. The question, Are there too many dentists, seems to be premature.

◆

OUR IMMENSE COUNTRY.

Few persons have an adequate idea of the immense extent of some of the western states and territories. Take Texas, for instance. A straight line drawn across the state at its greatest diameter is nearly as long as from New Orleans to Chicago. Place the entire population of the United States (fifty millions) in Texas and the state would not then be as densely populated as Germany. If the vast agricultural resources of the state were fully developed, it could easily support all that vast population. Montana, Idaho, Dakota, and New Mexico are almost as large. Of the twenty-two states and territories west of the Mississippi, only three are as small as all New England. These facts have no direct relation to dentistry, but they suggest possibilities to the young men who are prone to crowd into the cities to practice dentistry. Perhaps some of the "old settlers" who are alarmed about the encroachment of dental colleges could find more elbow room out west.

ONE OBJECTION TO PLASTIC FILLINGS.—Of the cements, it may be truly said that, in approximal cavities especially, they soon become a source of annoyance. However skillfully contoured, they become worn by attrition in a few weeks or months to a degree that allows of food crowding into spaces, or invites contact of the tongue with the slightest projection of enamel edge. To a nervously-constituted person this is a serious annoyance. At the same time the filling may appear nearly perfect to the eye of the dentist. Only those who, like the writer, have suffered this annoyance, can fully appreciate it.

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, September, 1887. No. 12.

MEDICAL DEPARTMENT.

CORRESPONDENCE.

BRITISH MEDICAL ASSOCIATION.

DUBLIN, August 11, 1887.

MR. EDITOR:—It has, for the second time, been my good fortune to attend the annual session of the British Medical Association. The former meeting was at Ryde, Isle of Wight, in 1881, just after the close of the International Medical Congress in London. It was in a locality hard to excel for natural beauty, and the meeting was a very enjoyable one, though somewhat overshadowed by the Congress. The meeting just closed at Dublin had no counter-attraction and was quite a success.

The magnificent buildings and grounds of Trinity College, situated in the very heart of the city, were placed at the disposal of the association, and here all the general, sectional, and other meetings were held.

The association was called to order by the retiring president, Dr. Withers Moore, of Brighton, who introduced the president-elect, Dr. John T. Banks, M.D.D. Sc. (Hon.), F.K.Q.C.P.I., Regius Professor of Physic, University of Dublin, who made the address which usually goes with the office and is accepted with thanks.

Sir B. Walter Foster, M.D., M.P., F.R.C.P. Eng., made the report of council as president of that body. This report was quite lengthy and full of interest, but only the main points can be given here. The membership was reported to be most satisfactory. It was in the neighborhood of twelve thousand, and there were four hundred applicants for admission. Financially, the association was in an enviable condition. The invested surplus of the association is £17,566, and the surplus over expenditures is in the near neighborhood of £4,000. The journal is a credit to the association and to medical science at large. New branches are reported from all parts—Colombo, Ceylon, Cape Colony and Halifax.

The following foreigners attended: C. Apostoli, Edm. Landolt, Eduord Meyer, of Paris; O. Chiara, Vienna; L. Kocher, Berne; C. Reymond, Turin; Arnold Schetelig, Homburg; Professor Unna, Hamburg; Professor von Zehender, Rostock; Wm. F. Smartt, Demerara; Chas. Stedman Bull, Geo. M. Lefferts, Virgil P. Gibney, New York; E. S. McKee, Cincinnati, delegate Ohio State Medical Society; Neal Hardy and Irene Hardy, Upper Sandusky, Ohio; W. H. Humiston, Cleveland, Ohio; T. F. Wood and H. D. Wood, Metz, Indiana; Alex. D. Sinclair, Francis M. Holden, Burnside Foster, Henry Cutler Baldwin, Boston, Mass.; C. B.Steman, Ft. Wayne, Indiana.

The president of the association delivered a lengthy address, retrospective in character, which was in parts interesting, in parts tedious. Like most of their presidents in this country and to some extent in our own, he was too old and had been chosen rather for what he had done than for what he was at the time able to do.

Dr. W. T. Gairdener, of Glasgow, delivered the address on Medicine, going into the subject whether medicine was really advancing or not. Edward Hamilton, of Dublin, delivered the address on Surgery. He urged the compliance with antiseptic rules and lamented the existence of the vivisection act. Samuel Haughton, M.D., D.D., Sc. (Hon.), D.C.L., S.F.T.C.D., a learned and eccentric individual, a thorough Irishman, made the addres on Public Medicine. He treated first of natural rights. These are: liberty, air, water, food, heat, and light. He then discussed death-rate and density of population, finding that as the latter increased the former was augmented. Dublin death-rate and sanitation came in for a large amount of attention, as it needs. A saving in the death-rate during the past five years by the exercise of sanitation, imperfect as it has been, has resulted in a saving of 3 per 1,000, or about 4,000 lives.

In the sections much good work was done which will hardly find space for mention here. In the section on Therapeutics and Pharmacology the chief subject up was the therapy of the uric acid diathesis and a demonstration by Prof. Unna, of Hamburg, on the improvements of the therapeutics of the skin. In Pathology, the Ætiology of Chlorosis and the Pathology of Empyema. In Public Medicine, the Influence of Modern Preventative Measures on the Prevalence of Infective Diseases, and How to Deal with Insanitary Property now Occupied by Artisans and Laborers. Psychology: Nervous Disorders Following the use of Anæsthetics, Private Treatment *versus* Asylum Treatment, and The Use of Electricity in the Treatment of Insanity. Ophthalmology: The Observation ane Treatment of Concomitant Strabismus. Otology: Tinnitus Aurium, Laryngology and Rhinology, Phthisis of the Larynx, The Reflex Neuroses of the Naso-Pharynx. Medicine: The Different Kinds of Aphasis with Reference to their Classification and Ultimate Pathology. Surgery: The Radical Cure of Hernia. Obstetrics: On the Prevention of Puerperal Fever, On the Management of Posterior Displacements of the Uterus. Dr. G. Apostoli, of Paris, was also present in the latter section, and read two papers, one on his method of treating uterine fibroids by electricity, the other on his his treatment of periuterine inflammation by the same remedy. Dr. Apostoli also gave several seances of his mode of treatment at the Rotunda Hospital to a large numbers of the members. His system was encouraged by such men as Playfair, Sir Spencer Wells, and Keith, Jr., who had been at his clinique at Paris, saw him work, and tried the method themselves.

Socially, the meeting was as great a success as scientifically. A soiree was given by the president and the Dublin branch at the Royal University of Ireland; the annual dinner was held at the same place on the next evening; a garden party was given by the president and members of the Dublin branch in the Fellow's Garden, Trinity College; a conversatzione was given by Surgeon-General Hazzard, C.B., P.M.O., Ireland, and officers of the medical staff at the Museum of Science and Art; the Dublin branch of the Irish Temperance Society gave a breakfast at New Leinster Hall; the Provost and Senior Fellows of Trinity College gave a dinner in the College. All the hospitals and clubs and places of interest in the city were thrown open to the members. Excursions were given in Dublin Bay, Power's Court and Dublin Waterworks, Glendalough and Ovoca, the battle-field of the Boyne. A large number of small dinner-parties, lunch and breakfast parties were made by members of the profession and others. In fact, the hospitality was immeasurable and can only be compared to that which one often finds in old Kaintuck. The Irish girls looked lovely and danced elegantly, but all the time there coursed through my mind that old song, "Tanigan's Ball."

There was considerable quarreling going on in the general meetings—quite as much as we find in our own national association. This was chiefly between the English on the one side and the Irish, frequently accompanied by the Scotch, on the other. It all arises from the fact that the British think themselves a little, or a considerable, better than the other divisions of the United Kingdom. It is the habit of some charitable institutions in England in advertising for gentlemen to fill vacancies on the medical staff, to limit the applications to those possessing the higher qualifications of the English licensing bodies. A resolution concerning this discrimination was introduced and after a stormy discussion was brought to a vote, and, the meeting being in Dublin, was carried with a rush, amid cheers. Another brush occurred after the delivery of the address by the president of the association, an Irishman. It was received impatiently by the English, no vote of thanks offered, and business proceeded with, when an Irish member raised the roof, figuratively speaking, and brought out a rousing vote of thanks for his fellow-countryman, making some telling hits against the English.

E. S. M.

◆

THE PROPER COURSE.—"In case of an accident, doctor—a broken leg, for instance—what is the best to be done while waiting for the physician?"

"Well," said the doctor, "I think the best thing to be done is to get his money ready for him."—*Puck*.

EDITORIAL.

A. B. THRASHER, A.M., M.D., Editor.

PUBLIC HEALTH.

While we as physicians live on the ill health, so to speak, of the public, yet as a class we take more interest than any other in the preservation of the Public Health.

Our instructions to our patients in reference to hygiene saves them more days of sickness than the drugs we administer while they are sick.

But this hygienic advice is frequently given from a too scanty stock. Few of our colleges teach hygiene—only incidentally. And physicians are too apt to rely on their knowledge of physiology and therapy as an equivalent for hygiene and not to go into even a superficial study of the subject.

One or two good works on this important subject should be in every physician's library, and they should be the very first books mastered and understood when he enters upon his active practice.

Ventilation, house sewerage, house heating—these should be careful subjects of study, as well as diet, clothing, etc.

By this means we will doubtless decrease the total amount of sickness, but we will materially increase the "ability to pay" of our *clientele*.

PHYSICIANS' CHARGES are as a rule much too low, and are often not collected in a business-like way. Under charging is sure to cause the patient to undervalue the services.

Cheap professional services should only be rendered by those who consider themselves cheap doctors.

If patients are unable to pay, *that* is another matter. No class of people give more charitable services than the physicians—but let it be understood that it is charity. Let your patients know that you consider your services valuable, and that when they have been rendered they owe you the money for these services just as much as if they had bought corn of you, and collect your bills just as promptly. Of course, the sickness by which the indebtedness is incurred may temporarily cause inability to meet the debt, but the debt exists until it is cancelled by payment.

Bills should be paid promptly while the memory of the service is still fresh, and by this means many a bill can be easily collected that if let run for a year or two would be lost. A man may be able to pay his bill now and would do it if presented, when from business reverses he might be unable to meet it in 3 or 6 months.

Charge a fair honest bill and collect it promptly if you desire to be thought well of and have a competency for your old age.

◆

TEA-POISONING ON THE COURSE OF SYPHILIS.—In the *Ejenedelnaia Klinitcheskaia Gazeta*, No. 6, p. 139, Dr. S. A. Smirnoff, the president of the Piatigorsk Balneological Society, publishes an interesting note on the subject. According to his extensive experience, Siberia sends to the Caucasian mineral waters the most obstinate and dilatory forms of syphilis. That fact may be explained to a certain extent by climatic conditions, want of timely regular treatment, and possibly also by some obscure peculiarities of the infection usually contracted by Siberian patients in China and Japan. An unmistakable influence is produced also by chronic tea-poisoning. The author speaks of so-called "tea-testers" (Russian tea-merchants use the English word as it stands), who, when present on the Chinese frontier for buying the article, are obliged to test from 150 to 200 specimens of strong tea-infusion daily. True, they do no swallow the infusion, but all the same a slow intoxication appears in them. The symptoms are loss of appetite, constipation alternating with diarrhœa, failure of general nutrition, periodical epigastric pains, enlargement of the liver with subsequent atrophic cirrhosis, dryness and sallowness of the skin, hypochondriacal frame of mind, marked failure of memory, failure of sight (weakness of visual acuity, sometimes diplopia), failure of taste and smell. When they happen to contract syphilis, they are very slow to yield to the mercurial treatment. To make them more amenable, Dr. Smirnoff treats them before all by alkaline Essentuk waters, with sulphur baths, and only afterwards passes to the specific means. The results are often admirable.—*London Med. Record.*

ABSTRACTS.

TREATMENT OF GASTRALGIA.

A CLINICAL LECTURE BY SIR JAMES SAWYER, KNT., M.D., F.R.C.P.,

Senior Physician to the Queen's Hospital, Birmingham.

GENTLEMEN,—I do not propose to-day to attempt a complete exposition of the nature and cure of gastralgia. I desire to draw your attention to some salient features of practical import in the definition, etiology, symptomatology, and diagnosis of the disorder, and especially to point out to you a means of treatment in which I have found confidence, based upon a long and frequent experience of satisfaciory results.

Gastralgia is a very painful affection. The pain has marked characteristics as to position, duration, and onset, and as to its sexual, constitutional, and temperamental associations. The disorder has been variously called gastralgia, cardialgia, and gastrodynia. The nomenclature of the Royal College of Physicians authorizes the last name, and it gives "stomach-ache" as a popular synonym. The malady is usually held to be a neurosis, affecting the gastric nerves. According to Dr. Leube, gastralgia is limited essentially to the sensitive sphere of the gastric nerves. (1) That the disorder is a neurosis is not quite proven—indeed, it is scarcely demonstrable. But the idea is a good "working hypothesis," which I commend to you. Romberg distinguished two forms of gastralgia: one, which he called gastrodynia neuralgica, he held to be a hyperæsthesia of the gastric branches of the pneumogastric nerves; the other, which he called neuralgia cœliaca, he regarded as hyperæsthesia of the solar plexus. Although Romberg has indicated what he thought to be the signs and conditions upon whcih a clinical differentiation of these varieties of gastralgia might be established, I agree with Niemeyer that in a given case it cannot be determined whether the patient's pains occcur in pnemogastric or in sympathetic distribution. As Henoch has

---

1. Von Ziemssen's Cyclopædia.

taught, although the distinction may rest upon a correct theoretical basis, it is one which is inapplicable and worthless in practice.(1) It has been objected that the term gastralgia is unscientific, because it is only the name of a symptom. In practice, however, and especially in private practice, we meet with many cases for which I know of no other name; and I apply the name to a clearly conceived and clearly defined condition. I call a case one of gastralgia in which pain, deep-seated and paroxysmal, in or about the stomach, of a neuralgic or quasi-neuralgic character, is the leading symptom. But this statement is inseparable from the following important qualification. Pain of the character and position described can only be regarded as that of gastralgia when it is unaccampanied by marked evidences of gastric or gastro-hepatic catarrh, and when, also, it is wholly unaccompanied by physical signs of structural disease either in the stomach or in its neighborhood. The latter part of this definition involves an essential and a negative conclusion. A negative conclusion, of course, in any case is proverbially difficult. Such a conclusion should only be formed in a supposed case of gastralgia after a complete examination of all the circnmstances. Further, a diagnosis of gastralgia should only be held in the conduct of a case of pain in the gastric region as a conclusion which is subject to frequent diagnostic revision; that is, such a diagnosis can only be continued when repeated physical exploration tails to reveal any other "coarser" interpretation of the patient's suffering. I desire to impress this last statement upon you as an important clinical caution, which you must especially remember when your patient is a man at or beyond middle life. In such a person the danger of mistaking a graver and more material condition for gastralgia is especially imminent. The diagnosis of gastralgia is one which should never be lightly made, nor negligently maintained. Pain in the gastric region, you should always remember, may long appear to be simply gastralgic—that is, independent of any local o.ganic basis,—when the appearance of a tumor, or the discovery of an aneurismal pulsation, or a sudden gastric or intestinal hemorrhage may prove a diagnosis so comparatively favorable to be tenable no longer.

Romberg's short and vivid description of an attack of the severest gastralgia has been accepted as classical. Let me read it

---

1. Niemeyer: Text-book of Practical Medicine.

to you. He wrote: "A violent contracting pain at the pit of the stomach supervenes suddenly, or after being preceded by a sense of oppression; it generally extends to the back, there is a sense of fainting, the face is fallen in, the hands and feet cold, and the pulse small, crampted, and intermittent. The pain attains such a pitch as to cause the patient to scream out. The region of the stomach is either swelled and distended like a ball, or, as is more frequently the case, it is drawn in, and the abeominal parietes are tense. It is common to find pulsation at the epigastrium. Pressure is not only well borne, but the patient frequently forces the pit of the stomach against some firm object, or compresses it with his hands. Sympathetic sensations occur in many instances in the thorax, under the sternum, or in the pharyngeal branches of the vagus nerve, while they are seldom met with in the superficial parts."(1) This is Romberg's account of a typical and violent seizure of that form of gastralgia which he called cæliac neuralgia or paroxysmal hyperæsthesia of the solar plexus. You may accept his clinical portrait as accurate, although it is doubtful whether he was correct in localizing the pain solely in neaves of the sympathetic system. Under the heading of gastrodynia neuralgica you will find in Romberg's excellent book a faithful clinical description of the milder cases of gastralgia, or "attacks of painful sensations in the stomach," especially as they are manifested in association with the nervous temperament, and with the reflex expressions of sexual irregularities in women. I have ventured from my reading and clinical experience to form the opinion that Romberg did not describe two distinct diseases under the several names of cæliac neuralgia and neuralgic gastrodynia, but merely one and the same affection, which I have been accustomed to call gastralgia, as he met with it in different degrees of severity. Of course a dual interpretation of painful neuralgic affections in the gastric region has an anatomical basis in the dual nerve supply of the stomach—namely, in the innervation of the organ by nerves of the sympathetic system, and also by the vagus. But, truly, in the words of Leube, "in the present state of uncertainty with regard to the mode of action of the gastric nerves, especially with regard to the conditions of sensation, and in view of the anastomotic connexions between the vagus and the sympathetic in the stomach, such a

---

1. Romberg's Nervous Diseases of Man. Translated for the Sydenham Society by Sir Edward Sieveking, M.d., etc.

division of cardialgia appears to be both theoretically and practically untenable."

Gastralgia may occur at any age. It is rare at the extremes of life. It is rarer in children than in old people. It is most commonly met with in early middle life. Like all neuralgias, it follows hereditary constitution, and is especially associated with the nervous temperament. I advis you to study temperaments. In them you will find many clues to morbid tendencies. Temperaments denote distinct types of physical form, of habits, and of capacities. A man of nervous temperament is most slightly built, and he is generally in a hurry. He is hyper-sensitive to all influences, and to pain amongst them. All his movements are quick, and he has a strong tendency to "fidget" with his ideas or with his extremities. His speech betrays him; he talks volubly, abruptly, and earnestly, often splitting up his phrases, or recalling and correcting them, and especially modifying qualifying words.(1)

As in all neuralgias, women are more liable to gastralgia than men. As, also, in all neuralgias, the manifestation of gastralgia is favored by every condition which reduces the vigor of a patient's "general health." Gastralgia is a frequent neuralgic development of hysteria; and, in women who are not hysterical, its incidence is often determined by the prostration of anæmia or by the exhaustion which arises from prolonged uterine discharges. In men gastralgia may be a consequence of sexual excesses or of masturbation. All these circumstances must be remembered and dealt with in the casual diagnosis and effective treatment of the disorder.

The diagnosis of gastralgia is not usually difficult. Pain is the leading symptom. When we are satisfied as to the genuineness of pain in the region of the stomach, its correct interpretation largely depends upon an accurate appreciation of various diagnostic data *per viam conclusionis*. I cannot deal exhaustively with this part of the subject to-day. I desire, however, to give you these three cautions, which I have learned in practice: (1) Gastralgia is not a wasting disease. (2) It is not safe to diagnose cancer of the stomach until you can *feel* the cancer. (3) Do not diagnose ulcer of the stomach until you have *seen* blood from the stomach, either in hæmatemesis or melæna. You may take it as a clinical truth, as the late Dr. Wilson Fox clearly insisted, that pain arising in the

---

1. I have given a fuller account of the nervous temperament in my **Contributions to Practical Medicine.**

stomach when the organ is empty, and relieved by the ingestion of food, is almost diagnostic of its nervous origin and nature.(1) Sometimes the pain of ulcer or cancer of the stomach may for a time appear to be relieved by taking food, but such a condition is highly exceptional. There is sometimes a kind of gastric "sinking," even amounting to craving for food, in gastric catarrh, and with greater rarity probably in gastric ulcer; the local discomfort is not, however, relieved by feeding, but, on the cantrary, usually made worse. There is another diagnostic sign of great importance in the recognition of gastralgia. It is this: firm pressure over the region of the stomach relieves the local pain. Some patients find this out for themselves, and press a closed hand or the upper rail of a chair strongly against the epigastrium, and so find relief.

My chief object in drawing your attention to the subject of gastralgia is to explain to you a plan of treatment which I have found very successful. I can tell you of a drug which cures gastralgia. Before you prescribe it, however, you ought to find out if there be any prominent pathological concomitants or casual antecedents of the disorder, and deal with them. Anæmia, sexual excess, overwork, work under wrong conditions, uterine discharges, masturbation, etc., must be appropriately met. But for the cure of gastralgia something more is usually necessary. Of all the directly therapeutic results in medicine with which I am acquainted, one of the most demonstrable is that which can be produced by the suitable exhibition of arsenious acid in uncomplicated gastralgia. I give one-twenty-fourth of a grain of arsenious acid, made into a pill with two grains of extract of gentian, thrice daily, between meals. The use of this remedy must be continued for a few weeks. In a case of moderate severity no other medicinal treatment is necessary. The gastralgic pains become less frequent and less severe, and recovery is steadily and surely attained. In severer cases I use some form of counter-irritation to the epigastrium, and I usually employ a rubefacient liniment of ammonia. In the severest cases vesication by a fly-blister is of service, and the blistered surface should be kept raw for some days by means of a daily dressing of savin ointment. But you must not rely upon treatment by drugs alone. Every hygienic adjuvant which tends to raise the strength of the patient is of high value in the cure of gastralgia. I especially advise you to make sure the suf-

---

1. Reynold's System of Medicine.

ferer feeds well and full. The diet should be generous. A "dyspeptic" regimen makes a case of gastralgia worse. When you are satisfied there is no, or but slight, gastric catarrh in the gastralgia of a fairly vigorous adult, you should direct a dietary after this plan: Breakfast: bread-and-butter or dry toast, with some fresh white fish, or some cold chicken or game, or a mutton chop, with a breakfastcupful of cocoa or weak tea or coffee. Dinner (1 P.M.): fresh beef or mutton, with bread, potatoes, cooked green vegetables, a fruit tart or a farinaceous pudding, with a glass of light bitter ale. Tea (at 5 P.M.): bread-and-butter or dry toast, with a small cupful of cocoa, tea, or milk-and-water. Supper (not later than 9 P.M.): white fish, or some cold chicken or game, or a little cold meat, with bread, and a glass of ale.—*The Lancet.*

EFFECT OF ANTIPYRETIC DRUGS ON THE LIVER AND KIDNEYS.—Dr. Porter presented the liver and kidneys of a patient who had had a moderate attack of rheumatism. Later, antipyrine was given at rather short intervals for the pupose of reducing the temperature, but it seemed to have had little influence. When the patient entered the hospital the temperature was 105° F., and after antipyrine was given it rose to 107°. Antipyrine was omitted and salicylic acid was given, when the temperature fell to 103°. Antipyrine again being given, the temperature again rose. Antifebrine was also given, but the temperature rose higher and higher, and the patient died with a temperature of 109° or 110° F. In looking over the literature he had found that some men who had experimented with such antipyretic drugs as antipyrine, antifebrine, thalline, etc., had observed the appearance of casts and albumen in the urine, and at the autopsy extensive metamorphosis of the liver and kidneys; but they claimed that this was of no practical importance. Some had also observed that in patients treated with antipyretic drugs, especially typhoid-fever patients, the duration of the disease was longer,—forty-two days instead of about thirty-two days, as was observed when baths and antipyretic measures other than these drugs were resorted to. One writer had said that by the use of antipyrine he had succeeded in getting the highest death-rate, but he was inclined to think that the patients were more comfortable while they lived. In studying the condition of the kidneys and liver in cases in which these antipyretic drugs had been employed, Dr. Porter had noticed in the history that the temperature had been higher than in cases in which such drugs were not employed, and he found a much greater degree of granular and fatty metamorphosis in the liver and kidneys. He had therefore come to believe that antifebrine, antipyrine, and thalline were not as safe drugs as we had been taught. The effect of the increased temperature occurring at some period of the disease after their use was to cause this marked metamorphosis of the liver and kidneys—primarily of the liver, secondarily of the kidneys.—*Philadelphia Med. Times*.

BORACIC ACID AS A MILK PRESERVATIVE.—The Vestry of Kensington recently referred to their medical officer of health (Dr. Dcdfield) and public analyst (Mr. Cassal) the question whether the addition of a small quantity of borax, or, more properly, borax with free boracic acid, to milk was injurious to health, and should therefore be treated as an offence against the Food and Drugs Act. The question is an important one, for the more strongly we reprobate adulteration and punish its perpetration, the more necessary it becomes to be sure that the offence has been committed. The report of the scientific officers is now before us, and the results may be stated in a few words. There is no doubt that the above-named preservative is frequently used by farmers in the country and by milk vendors in towns, perhaps sometimes by both. The quantity used is said to be seven grains per pint for milk and fourteen grains for cream. As there is a manifest possibility that it may be used twice over, not to speak of the risk of its being used in excessive quantity through carelessness or ignorance, the reporters are right in assuming that each quart of milk may contain twenty-eight grains of the preservative. This would mean an in the ash of 0·16 per cent., and even the half of this would be very percedtible in the analysis, for the ash of genuine milk seldom exceeds 0·7 per cent. It is manifest that this is no fraudulent addition in the common meaning of the term, for it does not add appreciably to the bulk of the milk, and cannot be ushd, as alum is in flour, to disguise a deficiency in quality. The antiseptic power of boracic acid is well known, and if it were proved to be innocuous its use would be commendable, as tending to prevent the waste of much valuable food material. But unfortunately its harmless chrracter is more than doubtful. There is, indeed, but little direct evidence available, but that little is decidedly against the drug. The most important is the memoir of Professor J. Förster, for a translation of which, published in another column, we are indebted to the courtesy of Mr. Charles Hancock, of the Kensington Vestry. It appears from this research that even small quantities of boracic acid are capable of exerting a distinctly injurious action on the human organism, hindering the assimilation of albuminoids, even in articles as digestible as eggs and milk. Such on action would be most serious in regard to infants and objectionable for all, and we must therefore regard the use of the preservation in question as a dangerous adulteration, which ought to be strictly prohibited. The caution is well worthy the attention of public analysts.—*The Lancet.*

RESORCIN IN ACUMINATED WARTS.—In the *Russkaia Meditzina*, No. 38, 1886, p. 639, Dr. G. J. Gatchkovsky, of Rybinsk, returns to the subject (*vide* London Medical Record, Dec. 1883, p. 507), and states that he most successfully treated thirty-four cases of acuminated condylomata by powdering with pure resorcin. He details an interesting case of a young man, aged 17, who never had gonorrhœa or syphilis, but suffered from moderate balanitis, and in whom in course of time there developed two large condylomata (one of the size of a little finger, another of that of a raspberry) and thirty smaller warty excrescences varying in their size from a hemp-seed to a big pea. Before coming under Dr. Gatchkovsky's observation (about six months after the appearance of first new growths), the patient remained without any treatment whatever. The small warts disappeared completely after four days' treatment with resorcin; the large condylomata dwindled away three or four days later. No recidive followed. According to the author, resorcin in acuminated warts was successfully used also by Dr. Ihle, who, however, employed the drug only in the shape of a 50 to 80 per cent. salve. Resorcin acts also not less brilliantly in cases of broad condylomata of the arms, as several cases of Dr. Gatchkovsky show; pain and the new growths themselves disappear within a short time after the commencement of powdering with the drug.—*London Med. Record.*

CASTELLAN ON THE TREATMENT OF GONORRHŒA BY INJECTIONS OF BICARBONATE OF SODIUM.—It is now generally admitted that gonorrhœa is a parasitic affection. Observation seems to prove that the parasitc can only exist in an acid medium, and the injection of non-irritant alkalies naturally suggests itself. Before commencing the treatment he ascertains by means of litmus paper the acidity of the pus—a sure indication of the nature of the affection. He uses a 1 per cent. solution of bicarbonate of sodium, to be injected three or four times daily. From seven to eight days' treatment is generally sufficient procure a marked diminution in the quantity of discharge, and convalescence is rapid. The injections at once relieve the scalding which accompanies micturition. The treatment is also applicable to gleet.—*London Med. Record.*

Treatment of Diphtheria.—In the *Russkaia Meditzina*, No. 43, 1886, p. 732, Dr. Lektorsky, of Terespol, in Poland, writes that, in treating faucial diphtheria, he obtains the best results from internally administering the following mixture: ℞. Decocti quinæ ex. ʒj. in ℥v.; chloratis potassæ ʒss.—j.; syr. quinæ ℥j. M. A teaspoonful every two hours. At the same time, he paints the parts affected every two hours (alternately with the mixture) with a solution of iron and carbolic acid, prepared after this formula: ℞. Liq. ferri sesquichlor. gtt. x.; acid carbolici gr. v.; glycerinæ, aq. destill. ana ʒss. M. In obstinate cases he also irrigates the parts (before painting with the solution), by means of a syringe, with lime-water, in order to accelerate the separation of false membranes and detritus.—*London Med. Record.*

A New Skin Disease: Lymphodermia Perniciosa.—The author (*Wien. Med. Jahrb.*, 1885, p. 129) describes under the above name a new disease which he observed in a woman, 39 years of age. On admission to hospital the patient was pale, had swellings of the cervical and inguinal glands, nodular infiltration in the palm of the left hand, as well as flexor surfaces on both forearms; and the clinical symptoms of a universal eczema. In the face, neck, and upper part of the breast the infiltration of the subcutaneous tissue was so great as to produce the appearance of leontiasis. The infiltration became nodular, and gave rise to serpiginous ulcers. The spleen enlarged, the leucæmia increased, and the patient died. The author regards the disease as lymphatic in its nature.—*London Med. Record.*

Early Menstruation and the Menopause.—A few years ago, Dr. Fordyce Barker stated it as the result of his observation that, contrary to the common impression, the menopause was apt to occur early in women who had not menstruated for the first time until they had passed the usual age for the beginning of the menstrual function, and *vice versa.* This view war recently supported to a certain extent by Dr. Rouvier, professos of gynecology at Beyroot, in a memoir on "Menstruation in the Women of Syria," presented to the Paris Société de Médecine, brief mention of which we find in the *Union Medicale.* Dr. Rouvier has found that when menstruation begins unusually early, the menopause occurs neither earlier nor later than in the generality of women.—*New York Medical Journal.*

DANGER OF MORPHINE INJECTIONS IN STRANGULATED HERNIA. —Dr. Routier calls attention to the danger which may result from the administration of morphine in certain cases. He gives the example of a patient suffering from strangulated hernia. She had been seen by a medical man who, having made an ineffectual attempt to reduce the hernia, administered a hypodermic injection of morphine, under the influence of which the urgency of the symptoms subsided and gave rise to a false impression as to the nature of the case. The patient died, and at the *post-mortem* examination no less than 75 centimetres of gut were found to be gangrenous.—*London Med. Record.*

CASTRATION OF CRIMINALS.—The following is the recommendation of an enthusiastic ssciologist who proposes castration as a means of limiting crime. The good efiect of this kind of punishment upon the criminal class would be fourfold.

1. No offspring with an inherited tendency to commit crime.
2. An added terror to the punishment inflicted for breaking the laws.
3. A gradual improvement in time of the morals of the public at large,
4. An improvement in the disposition of the person operated upon.—*Medical News.*

BETTER WAIT A WHILE.—*Patient:* "What would you think of a warmer climate for me, doctor?"

Doctor: "Great Scott! man, isn't that just what I am trying to save you from?"—*Medical Era.*

◆

THE
CINCINNATI
Medical and Dental
JOURNAL.

Vol. II. Cincinnati, September, 1887. No. 12.

DENTAL DEPARTMENT.

EDITORIAL.

FRANK W. SAGE, D. D. S., - - Editor.

THE UNRECORDED UTTERANCES OF THE LOBBIES.

In almost all dental conventions there is an undercurrent of opinion which never manifests itself openly in the discussions, but which sometimes ruffles the surface of sentiment beyond the confines of the assembly. It takes on the semblance of a freer interchange of views than those openly expressed in the formal sessions. It is often of value in determining the boundary line between what is to be received as practicable, and that which is the expression of mere theory. For it is not to be expected that any assembly of professional men, or tradesmen, will ever be convened which does not embrace in its number some who, even unconsciously, deal more in the fanciful and unattainable than in the real and available. It is usually during the lull between sessions that this undercurrent makes itself felt, and often provokes more animated discussion than characterizes the formal occasion whence it gathered strength. In the hotel lobbies it bubbles and swirls in unrestrained vigor. The member who is too slow of conception to readily arrange his ideas and give them utterance on the floor of the convention, here finds an opportunity to express himself. And he usually has very good ideas. Oftentimes he requires the mild stimulus of a cigar, or a wooden tooth-pick, to enable him to properly emphasize the point he seeks to make. He holds the same relation to the orators of the convention that the critic holds to the writers whose works he reviews. Briefly stated, he is no orator, but merely a good talker, tempted to no flights for the sake of display, but straightforward, concise, and to the point. Of course, he is not infallible, and he knows it. He may blunder, but he inquires where he cannot direct; he sifts, and compares, and arrives at positive conclusions finally.

A convention would be incomplete without these between-the-acts diversions. Ideas, which perhaps appear unprofitable and vain when utterance is given to them by speakers, provoke outside discussion and stimulate informal expressions of views and opinions on the outer edge of the circle. These expressions are caught up and find their way into the odds-and-ends columns of our journals, and often form a valuable complement to the reporter's record. The fear of what others will think of them, the dread of ridicule, or even of kindly criticism, no doubt largely deters members from a free expression of private opinion in public discussions of all kinds. These after-discussions divest the main discussions of their florid and false features, prune away superfluous growths, and cultivate habits of critical insight such as cannot but yield valuable results to the participants and their audiences. The member who makes a bombastic speech on the floor may provoke dissent in the form of a speech equally bombastic, but the critic in the lobbies is apt to be impartial in his judgment of both. He penetrates all disguises and exposes all artifices, from whatever quarter they may proceed. Thus, it happens sometimes that the chaff of the discussions is swept away by the surface waters, while the grain is found floating quietly in the eddies which revolve beyond the outward limits of the on-rushing tide.

AT the recent meeting of the American Dental Association, Dr. W. N. Morrison, of St. Louis, offered a resolution providing for an appropriation of $500 to be offered as a prize for the discovery of a durable dental cement. The resolution was tabled for one year, and a committee of three appointed to confer on the matter.

WHAT IS THE BEST CROWN?

While it is perhaps impracticable to adapt any one one of the various methods of crowning roots to the requirements of all cases, the dentist who attempts much of this kind of work usually has an opinion as to what method is the best. Years ago, when the so-called Richmond method of driving a ferule over the root to the alveolus was introduced, many sagacious heads foresaw fatal injury to the periosteum in this heroic method. And yet this objection seems only of late to have received serious notice in the pages of dental journals. To-day it is questioned whether a band projected ever so slightly under the gingival border will not ultimately work more injury than benefit. It is doubtful whether any method thus far devised would be effective in preserving roots longer than twelve or fifteen years. What the band accomplishes by way of protecting the root from decay, is probably offset by its injurious effect upon the periosteum. The Logan crown, with its hollowed base and thin cervical edge, seems to meet all reasonable requirements in securing a tight, moisture-proof joint, without the band. The peculiar feature of its construction,—the baking of the pin into the crown and the shape of the pin, or post,—contribute greatly to ease and accuracy of adjustment. It is claimed that when fastened in with cement, the joint between the end of the root and the crown will remain impervious to moisture for a long time. This seems probable, when we consider the possibility of securing an almost perfect adjustment with very slight exposure of the cement. The posts, however, seem rather too pliable, and may need improvement in that respect. For ease of adjustment and stability, the Logan crown seems entitled to a share of favor. —[ED.]

NO MAN can successfully conduct a profession on any other than strictly business principles. Promptness in collecting and in paying bills, faithful service, perseverance and energy, are as indispensable requisites to the professional man as to the business man. Lack of system means growing embarrassments, failure of resources, and subservience to petty cares, which leave no room for growth and improvement.

CONSTITUENTS OF DENTAL CEMENTS.

According to statements made in a recent exposé by a firm of manufacturing chemists, cements are made slow-setting by introducing foreign substances to retard chemical combination- Slow-setting cements are therefore apt to be more friable, and are not homogeneous in character. Years ago a dentist, now deceased, of Cincinnati, gained a certain reputation for making oxy-chloride of zinc fillings of unusual durability. In a moment of leisure he once confided to the editor part of his secret (if secret it was), and offered to give more explicit instructions at a future time. His sudden death left that promise unfulfilled. This much was learned: the cement was mixed quite thin so as to admit of being poured into the cavity, after which it was left undisturbed for half an hour or more, being kept dry meanwhile. No trimming or shaping of the filling was attempted until quite hard. We removed several of his fillings and replaced them with gold for a gentleman who affirmed that they had been in the cavities for twelve years. The fillings were in approximal cavities of upper incisors and bicuspids, were but slightly cupped out, and were of a dirty brown hue, like old Hill's stopping plugs.

FAREWELL ANNOUNCEMENT.

With this, the closing number of the second volume of the JOURNAL, the labors of the editor of the Dental Department end. It is not without regret that we relinquish a task at once congenial and responsible. But it seems expedient, in view of other pressing duties requiring all his strength and endurance to accomplish, that the present editor should give way to another, better able to fulfill the conditions of the position. Trusting that he who succeeds to the charge of the Dental Department of this journal will derive as much pleasure and satisfaction from his labor as has been the writer's lot, we bid our readers farewell, and retire to seek a much-needed rest from literary labor.

FOR excavating sensitive cavities the use of sharp instruments *warmed to the temperature of the blood*, is being urged from various quarters.

OPERATIVE DENTISTRY.

[FROM PROCEEDINGS OF ILLINOIS STATE DENTAL SOCIETY.]

Dr. Noyes, who opened the discussion, spoke as follows: My attention has been specially directed to the cervical borders of fillings in the last few months, with the result that I have come to the conclusion that this point is often neglected. The proper finishing of cervical margins is of the greatest importance, but does not receive proper attention oftentimes, because at the end of a long operation both the patient and operator are tired and nervous. In filling a tooth the first important point is to have the edges of the cavity carefully smoothed before inserting the filling. The next point of great importance is plenty of space—separation. It often happens that while we may have sufficient room to fill a tooth properly, there is not enough for finishing. The next point is complete exposure to the eye of the edge of the filling near or above the gum. An orange-wood wedge may be used for securing this, the painfulness usually resulting therefrom being controlled by the application of cocaine to the gums. In using disks, great care is necessary, the tendency being to trim away the lower third of the filling too much, the upper not enough.

Do not use pieces of gold so large as to obscure the view or endanger the certainty of thorough packing. First and second permanent molars, soon after eruption, may sometimes be filled with gold, but never with amalgam. Tin is the best material in a majority of cases. I must not be understood as condemning the use of amalgam entirely, as I think it an excellent material in its proper place.

Dr. Green: I fill the teeth Dr. Noyes has just mentioned, up to fourteen years, with cements. The average durability of snch fillings is about four years.

Dr. Stevens: I am opposed to the use of cocaine. From my observation and reading I should as readily consent to use chloroform for an anæsthetic. In one or two cases death has resulted from the use of the two per cent. solution of cocaine. I do not believe in employing corundum disks, but use a great many of sandpaper. Broken pieces of files may be used to advantage as matrices, instead of the patented and advertised articles.

Dr. Cady: If Dr. Stevens will try the Brophy matrix, he will understand its great advantages over the office-made instrument. Until about six months ago I was, after having tried a number, oppored to the use of any form of matrix, but at the earnest solicitation of a friend whose operative abilities I recognize, I tried the little instrument devised by Dr. Brophy, and was much pleased with it. I am satisfied that its use will, in many cases, save a vast deal of time and nervous strain to both patient and operator. The method of using gold and tin combined at the cervical margin, where the cavity extends to or below the gum, is admirable. The first third of the cavity I always fill with non-cohesive gold, and the finishing is done with No. 60, conesive. Sandpaper disks are valuable adjuncts to the operating case, but I prefer those of emery-cloth. These, when moistened with oil, cut faster and with less pain to the patient from heat generated by the rapid motion. In addition to this, they are more pliable, and can be directed with a properly shaped instrument into depressions and irregularities of surface that no other disk will reach.

Dr. Newkirk: I find most of the finishing tapes on the market too wide for my purposes. The narrow tape, to be obtained at dry-goods stores, should be employed. I use the scalers of Dr. Cusding's set to follow out and cut off thin laminæ of gold at the cervical edge.

Dr. Stevens: Sandpaper disks, properly used, are better than tape, or anything else, for finishing the cervical edge.

Dr. Harlan: Many fail in adjusting the rubber-dam, because the mouth and teeth are not first thoroughly cleansed. This should be attended to first of all. Others use the ligature too thick, and without scraping. I do not believe in the indiscriminate use of matrices, but when they are used the same care in all steps of the operation should be observed as when they are not. Hydraulic gutta-percha is the best material for wedging. In the young there is great danger to the pulp and the peridental membrane in rapid separation. The separator, in any form, should be used very judiciously.

Dr. Woolley: I believe the matrix is a valuable instrument in its place, but the laws governing its use should be recognized.

Dr. Brophy: If tin and gold, or tin alone is used at the cervical margin, there will be no occasion to use at that point either disks or strips in finishing. All the polishing necessary can be done with the burnisher in most cases. If it is desirable to use anything more, Dr. Parmly Brown's strips, used with corundum mixed with glycerine to a paste of the consistency of honey, will be found superior to all else. Sandpaper disks and tape bear no comparison. The testimony of a gentleman concerning an instrument he has never used is of little value. Matrices are invaluable in many cases. They are frequently so in using amalgam, and more often with gold. In using them no retaining pits should be made, nor any groove made at the cervical margin. The floor of the cavity should be left smooth, and gently sloping toward the gum from the interior. Anchorages should be made in the lateral walls, some distance from the bottom, and sufficiently far from the top to preclude weakening the masticating surface. I hope the old methods of preparing and filling cavities are past, not only on our own account, but for the benefit of the community at large. It is impossible to use a piece of broken file for a matrix with success. With such an instrument we have a flat, unyielding surface, that will not conform to the tooth. Fillings made by its use are invariably flat and without contour, and the cervical margin is always a point of uncertainty. I agree with Dr. Harlan, that the indiscriminate use of matrices is wrong, but so is the indicczriminate use of almost any instrument that can be mentioned. It is best to start the separating process slowly. In certain cases, nothing better has been devised than Perry's separator, and this is specially true in country practice, where patients come many miles. Use the instrument carefully, turning slowly until slight pressure is obtained. Then separate, stopping often to turn the screw up a little more, until the space desired is made. I want to urge the use of soft gold, or better still, tin and gold, at the cervical margin and for the first third of cavities. Injudicious use of the ligature is often the cause of pyorrhœa alveolaris, from forcing the gum back and allowing the formation of salivary calculus.

Dr. Black: I want to utter a word of warning regarding the use of the matrix when the bottom of the cavity is bowl-shaped. The gold, in such cases, will roll up, or turn one side, and the filling will be insecure from the start. I think it necessary to make the bottom of the cavity angular in some cases, to prevent this Failure in contouring approximate surfaces of molars is the cause of more complaints among our patient than anything else, perhaps. In cases where decay has allowed the teeth to come together too closely, we should wedge a great deal, but slowly, because we must wedge so much. The cavities should often be filled temporarily, in order to wedge as desired. After the considerable space necessary is obtained, a matrix should be adjusted which will fit closely at the cervical margin. This must be loosened or removed at the proper point, and the filling contoured and finished.

Dr. Allport: I must condemn the general use of matrices, while recognizing the value of their occasional employment. I do not believe a good operation can be made with a band matrix when the cutting edge is larger than the neck of the tooth. A perfect fit cannot here be made at the cervical edge. One use to which the wedge may be put is to hold a tooth still. I am glad to hear non-cohesive gold favorably mentioned. I have advocated its use with broad instruments for twenty years. I have seen hundreds of teeth spoiled by improper preparation of their cavities, and the subsequent breaking away of sharp or thin edges in filling. I am in the habit of polishing the edges of cavities with pumice stone. If proper care is exercised in preparing and filling a tooth, but little finishing will be required. I have little need of retaining points. In concluding, let me urge the use of large instruments. —*Independent Practitioners.*

◆

GOLD will only melt at a comparatively high temperature, as we all know, but what is not generally known, the *Jeweler's Journal* says, is that if two per cent. of silica be added to the gold, it can be melted over the flame of a common candle.

From the same source the reader may learn that a pretty alloy, said to resemble gold exactly, can be made with 16 parts copper, 1 of zinc, and 7 of platinum. The copper and platinum are covered first with borax and then with powdered charcoal and melted, then the zinc added, and the alloy thus produced is exceedingly malleable, and can be drawn into the finest wire, while it never tarnishes.—*Scientific American.*

DISK CUTTER.—I take a No. 10 (¾ in.) gun wad punch and drill a hole up into the centre of the shank. In this hole is driven a steel pin, the free extremity sharpened and on a level with the cutting edge of the punch. From a sheet of sand or emery paper, shellacked on the back, can be punched dozens of disks, perforated in the centre ready for mounting.—F. L. D., in *Archives of Dentistry.*

OPINIONS CULLED FROM VARIOUS EXCHANGES.

A SIMPLE and quick way to make solid grinding surfaces for bridge or crown work, is as follows: procure a natural tooth corresponding to the tooth to be made; lay a piece of cuttle-fish bone on the bench soft side up, and then press the occluding surface of the natural tooth into the soft cuttle-fish bone; on removing the tooth a perfect impression will be left in the soft bone. Now melt some scraps of gold and while fluid pour into the impression and press the gold while soft into place with a smooth flat instrument, the result will be a perfect copy of the natural tooth. This is the way jewelers cast gold ornaments.—E. N. HAMILTON, Ontario, Cal., in *Items of Interest.*

BRIDGE WORK is sweeping into the profession with lightning speed, and the next few years will see many noble successes, and many lamentable failures. It behooves us as sensible men, to stand as a unit against its unwarranted use.

First seized upon by a class of men of mercenary spirit, it was inserted in every case where there remained a few old stumps, provided the patient was willing to pay for the experiment. The reputable prastitioner is a gainer in this one direction, that they caused the idea to spread, by the liberal use of printer's ink, and thus brought to many, who would otherwise never have heard of it, the knowledge that teeth could be inserted without a plate.

OBSERVATIONS ON ARTIFICIAL CROWNS.—From observations of the results of my own operations, as well as those of others, I have come to the conclusion in at least two-thirds of the cases where a metal band or cap is used to cover or encircle the root or tooth, the dental ligament is subjected to more or less injury, this being the case as time elapses, the band, that at the completion of the operation was invisible, becomes in some cases painfully apparent, this I attribute to the elongation of the root, and possibly a slight recession of the gingival margins of the gums, both being brought about by the aforementioned injury afflicted when the cap or band is driven home. Any one with any experience will know that this state of affairs does not result where the old-fashioned wood pivot is used, or in fact any class of pivot minus the band.

It seems to me that in our endeavors to make the most permanent and cleanly operation—for there is no doubt but the stamped gold cap, or the porcelain faced gold cap with platina pin are the best things in the way of artificial crowns—we promote a source of distrust in our minds as to the durability and satisfactory nature of our operations, no matter how artistic or beautiful the immediate results may be.—W. S. MITCHELL, D.D.S., London, Eng., in *Dental Review*.

PURE MERCURY.—In making a dental amalgam, use always pure mercury, bought from a trustworthy dealer, who knows that the article is pure. The use of impure mercury must make a poor amalgam with the very vest alloy that can be obtained. Keep the mercury constantly covered with alcohol, which should remain clear, and the surface of the mercury appear brilliantly bright. Take a common glass drop-tube with bulb; compress the bulb; pass the glass nozzle through the alcohol into the mercury; release the pressure on the bulb, and the tube will fill with mercury, which may then be dropped into the hand or mortar in as small a quantity as is desired. By this method the mercury in the tube and bottle is kept from contact with the air, and will remain bright and clean until the last. If through neglect the mercury should become oxidized, wash it by shaking it in the bottle with alcohol renewed again and again until perfectly free from discoloration by the mercury. The disesteem in which amalgams are held by many dentists and patients may be in great measure chargeable to the use of impure mercury. Every dentist experienced in the construction of silver plates knows the importance of making his solder bright and clean. Similar conditions should for like reasons be observed in making a dental amalgam with mercury, which ought not only to be pure and kept clean, but for the production of the best results it ought never to be mixed with the alloy in the hand, because of the inevitable film of dermal secretions that will be spread over the surface of the mercury, and by so much hinder the perfect union of the metals. The mix ought therefore to be made in a clean rubber or vitrified mortar with a rubber or glass pestle, and the pellet compressed in a piece of washed and dried buckskin. If with these precautions care is taken to keep the alloy in a tight-stoppered bottle, amalgam fillings of unwonted excellence may be made.—*Cosmos*.

ean
old
oes
dis-
e of
ate
, in

ays
hat
oon
the
air
ht.
lb.
ase
ich
an-
ind
nd
be-
hol
by
by
to
he
his
ons
ch
on
he
ill
er
be
ss
ed
ne
ed

41C1140

3 2044 103 060 422